

HEALTH MANPOWER LEGISLATION, 1975

HEARINGS
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON
LABOR AND PUBLIC WELFARE
UNITED STATES SENATE
NINETY-FOURTH CONGRESS

FIRST SESSION

ON

S. 989

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO REVISE
AND EXTEND THE PROGRAMS OF ASSISTANCE UNDER
TITLE VII FOR TRAINING IN THE HEALTH AND ALLIED
HEALTH PROFESSIONS, TO REVISE THE NATIONAL
HEALTH SERVICE CORPS SCHOLARSHIP TRAINING
PROGRAM, AND FOR OTHER PURPOSES

AND RELATED BILLS

PART 2

SEPTEMBER 16 AND 26, 1975

Printed for the use of the Committee on Labor and Public Welfare



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Committee on Labor and Public
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HEALTH MANPOWER LEGISLATION, 1975

Maldistribution of Physicians

TUESDAY, SEPTEMBER 16, 1975

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:40 a.m., in room 2228, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy and Beall.

Committee staff present: LeRoy Goldman, professional staff member; and Joy B. Cutler, minority counsel.

Senator KENNEDY. The subcommittee will come to order.

OPENING STATEMENT OF SENATOR KENNEDY

Today, the subcommittee continues its hearings on health manpower legislation. This morning we will hear from the administration. Representing the administration will be Theodore Cooper, M.D., the Assistant Secretary for Health from the Department of Health, Education, and Welfare.

The health manpower legislation expired more than a year ago. Since that time, the Congress has attempted to draft a new law which will directly attack the major health manpower problems which the country faces. Over this period, the administration has not had a program that has been seriously considered in either the House or the Senate.

The administration has recognized the gross geographic maldistribution of physicians. But it has proposed little or nothing to overcome the problem.

The administration has recognized the maldistribution of physicians by specialty, but it has proposed little or nothing to overcome the problem.

The administration has recognized the problems associated with inadequately trained foreign medical graduates but the administration has proposed nothing to come to grips with this problem.

The administration has recognized the inequities in this Nation's "crazy quilt" pattern of licensure, but the administration has proposed no program to deal with the problem.

These four problems must be directly confronted. And with the Federal Government now subsidizing more than one-half of the costs

of medical education, they must be confronted in the manpower legislation.

When the administration appeared before the committee in July, Dr. Endicott reported that the administration was reexamining its health manpower policy. I am particularly eager to learn of the results of that reexamination. I am hopeful that the testimony today will lay the groundwork for quick and effective action on this legislation.

The maldistribution of health manpower, especially physicians, is clearly the Nation's most severe health manpower problem. Today, thousands of U.S. communities and neighborhoods do not have an adequate supply of doctors.

The situation results from the fee-for-service payment system which allows physicians both to set their own fee levels and to generate the demand for their own services. By manipulating fee levels and quantity of services provided, it is possible for a doctor to earn a handsome income virtually anywhere in the Nation.

As a result of this system, America's physicians have clustered in the socially and culturally attractive suburban and small urban communities. And while these areas have benefited, thousands of rural communities and inner-city neighborhoods have been shortchanged.

The per capita physician supply in suburban areas is now 2 to 4 times that in rural areas, and up to 8 to 10 times the supply in inner-city areas. No other essential community resource—not teachers, not policemen, not sanitation workers—are so maldistributed.

More than 20,000 additional physicians are now needed in rural communities. And due to the age of rural doctors, this shortage is projected to grow to more than 30,000 by 1985; 5,000 to 10,000 more physicians are now needed in inner-city urban areas. And special groups and institutions—Indians, migrants, prisons, State mental hospitals, Veterans' Administration and Public Health Service hospitals—need another 2,000 to 3,000 doctors at the present time.

The military, of course, needs approximately 5,000 physicians at any point in time. So, the total number of physicians needed by underserved groups is between 25,000 and 30,000.

In its presentation to the subcommittee last year, the administration spokesman, Dr. Charles Edwards, readily admitted that rural and inner-city areas had a severe need for additional physicians. He noted that existing Federal programs, especially the capitation and loan forgiveness programs, had not successfully addressed the problem.

But the solution the administration proposed at that time, a mere \$22.5 million of National Health Service Corps scholarships—enough to provide scholarships for only 2,000 students—would certainly not solve our geographic maldistribution problems.

A second major health manpower problem is the specialty maldistribution of physicians. We do not have an adequate number of primary care doctors. We have too many surgeons and specialists.

In Britain, more than 75 percent of all doctors are in the primary care specialties. In the Kaiser Health Plan, a large, well-organized health maintenance organization, two-thirds of the doctors are in the primary care specialties. By contrast, in the United States today,

only 35 percent of all active physicians provide primary care. And only 31 percent of physicians now in residency training are expected to enter the primary care specialties.

The medical specialty practiced by any physician is, of course, the result of the postgraduate residency training which he has received. In this case, the maldistribution of physicians by specialty is actually the cumulative effect of a maldistribution of postgraduate physician training programs and positions. The maldistribution of postgraduate training programs results from the system used to accredit those programs.

The current accreditation system now considers only the quality of a proposed residency program. In no way is the need for a program and its graduates considered.

This system responds to the needs and desires of hospitals, their administrators and departmental chairmen. No overall balance in terms of the needs of the people is ever considered. Given the desire of hospitals for cheap labor and of medical school departments for prestige, it is not surprising that the system has established almost twice as many positions as there are graduates of U.S. schools, and that the programs and positions are badly distributed among the specialties. The system now produces relatively too many surgeons and subspecialists and not enough primary care physicians.

This again is a problem which the administration recognized in its appearance before the subcommittee last year. At that time, it was noted that there are both a shortage of some specialists and a surplus of others. Yet the administration's proposal was limited to the expenditure of an additional \$25 million to support the training of family practitioners. There was no proposal at all to reorient internal medicine and pediatrics toward primary care. There was no proposal at all to reduce the number of physicians training in the surgical specialties.

This morning, the subcommittee will be most interested in the administration's proposal in this second important area.

The third health manpower problem is the excessive reliance on foreign medical graduates, FMG's, by the U.S. health care system.

In 1937, more than 20 percent of the physicians in the United States were graduates of schools outside of the United States; more than 33 percent of the doctors in training in that year were FMG's. In 18 States, more than half of the new physicians licensed in 1973 were FMG's.

Our reliance on such a large number of FMG's raises questions in two areas: quality of care and international relationships. There is considerable evidence that the quality of medical care provided by foreign medical graduates, however appropriate for the nations in which these the individuals are trained, is not up to U.S. standards. It is estimated, for instance, that only 20 percent of FMG's could pass the National Board examinations passed by 89 percent of the U.S. graduates. And even after 3 or more years in the United States, FMG's perform significantly less well on Specialty Board examinations. Individual horror stories recounted by senior physicians and fellow house staff alike are numerous. Finally, the physician-patient relationship possible between a doctor who does not speak good English or under-

stand the nuances of the American culture and an American patient, must, in almost any case, be less than optimal.

There is a second consideration. It is the propriety of the wealthiest Nation on the Earth importing thousands of doctors from developing nations, nations where millions of people are without even the most rudimentary of medical services. It might be expected, in fact, that a wealthy developed nation would export physicians, as well as other components of medical care, to the underdeveloped nations.

Last year, the administration agreed that the excessive reliance on foreign medical graduates was generally an unwise practice. At that time, the administration listed a series of alternative approaches to resolve this problem. No legislation was introduced, however.

The fourth major health manpower problem faced by this Nation is that of the licensing of physicians and other health care professionals. Each State now operates its own individual health professions licensing system. Many of these systems are inadequate. Once issued, a physician's license is almost never rescinded. Only 12 physicians in the entire country lost their licenses for malfeasance or incompetence last year. Twelve of more than 300,000.

The information on physician practice available from the State licensure boards—even basic information like name, location, and practice specialty—ranges from the nonexistent at worse to non-comparable at best.

We have heard a great deal recently about malpractice. The malpractice crisis is, at its heart, a quality of care crisis. And the quality of care crisis must have as its heart a licensing crisis. For a practitioners' license is now a patient's primary assurance of quality medical care. If the licensure system worked, if it insured that only competent—continuingly competent—physicians practiced medicine, there would be many fewer malpractice suits.

Last year, the administration spokesman said he agreed with "the need for uniformity among States in terms of their licensure requirements." But last year, there was no administration proposal to do anything in this area. The subcommittee will be interested in the administration's proposal in this area this year.

In summary, the Nation faces major problems in four health manpower areas. Repeatedly, administration spokesmen have confirmed the existence and persistence of these problems. Yet, the administration has proposed to do little, or even nothing, about these problems.

Today, we hope Dr. Cooper will change all that, in his description of a new administration proposal. We hope this proposal will address these problems. And then we hope that we can meet that challenge here in the Congress.

I recognize my colleague, the distinguished Senator from Maryland, who perhaps more than any other member of the committee has taken a very keen interest in the whole problem of health manpower, and look forward to whatever comments he might make.

Senator BEALL. Thank you, Mr. Chairman.

Incidentally, Senator Schweiker, who is the ranking minority member of the committee, has a statement that he would like included in the record.

Senator KENNEDY. It will be so included at this point.
[The statement of Senator Schweiker follows:]

**STATEMENT OF HON. RICHARD S. SCHWEIKER, A U.S. SENATOR
FROM THE STATE OF PENNSYLVANIA**

Senator SCHWEIKER. During the last decade, Federal support of medical education was in response to the critical shortage of physicians and other health professionals. However, while shortages still exist, the primary issues surrounding health manpower today are geographic maldistribution of physicians, maldistribution of specialties, and the increased reliance on graduates of foreign medical schools.

The problems involving maldistribution, both geographic and specialty, have an obvious implication on the availability and accessibility of care to many segments of our population. These problems make the promise of access to quality health care for all Americans an unkept promise.

Amid this we face the additional issue of foreign medical graduates. It is ironic that many young people are complaining they are unable to enter medical school while at the same time we discover a heavy reliance on foreign medical graduates to provide services in our community hospitals across the country. It is certainly hard to justify our sizable investment in medical schools while admitting to this phenomenon.

The fundamental question, therefore, is the obligation and responsibility of the Nation's medical schools to come to grips with these problems in response to the investment we are making in them.

The subcommittee will consider several bills this week. They all try to answer what this Nation's obligations and responsibilities are, in the face of the problems confronting us. However, in its deliberations, and ultimately in reporting a health manpower bill to the Senate, the Labor and Public Welfare Committee must insure that we maintain adequate and stable institutional support for our medical schools. This support must be undertaken through the capitation grant mechanism, through the National Health Service for scholarships and student loans, through some program for eliminating the geographic and specialty maldistribution problems, and finally, by eliminating the dependence upon foreign medical graduates.

Senator KENNEDY. You may proceed, Senator.

**STATEMENT OF HON. J. GLENN BEALL, JR., A U.S. SENATOR FROM
THE STATE OF MARYLAND**

Senator BEALL. Mr. Chairman, I welcome these hearings. They are long overdue.

Health manpower is certainly one of the critical health problems confronting our Nation. In addition, action on health manpower problems is critical to our resolution of other health problems.

Last year, the Senate, by an overwhelming vote of 81 to 7, passed the manpower bill authored by Senator Taft, me, and others. The measure has been introduced in the 94th Congress as S. 1357, the

Health Manpower and Shortage Area Assistance Act of 1975. This bill would:

1. Require health professional schools, as a condition of Federal capitation, to reserve 25 percent of their enrollment positions, for the national need, for individuals who volunteer and agree to practice primary care in a medically underserved area. Students volunteering to enter the reserved positions would be entitled to a scholarship. Management grants, not to exceed \$25,000, would be authorized to assist in setting up practice.

2. Continue capitation grants to the various health profession schools in general at current authorization levels. In addition, health profession schools would be required to meet certain conditions. For example, medical schools, in addition to a one-time enrollment increase, would also be required:

(a) Make primary care comparable to other major clinical specialties.

(b) Have either family medicine postgraduate positions equal to 10 percent, 15 percent, and 20 percent over the 3 years of the bill, or comparable primary care equal to 35 percent, 40 percent, and 45 percent over the same period; and

(c) Limit the number of foreign medical graduates, FMG's, in affiliated postgraduate training positions to 40 percent, 35 percent, and 25 percent, respectively, over the 3-year period.

3. Authorize \$20 million annually for a disadvantaged assistance program.

4. Authorize \$140 million over 3 years for grants for training, traineeships, and fellowships in family medicine and comparable primary care.

5. Provide for a new \$125 million, 3-year program, "Community-Based Health Manpower Education Program," to develop community-based primary care training centers.

6. Condition the admission of alien physicians to the United States upon the alien passing the same examination as required for graduates of U.S. medical schools, demonstrating competence in oral and written English, and

7. Provide for a 3-year extension of Allied Health Professions program.

Because the House-Senate Conference Committee last year was unable to reconcile the differences in the House and Senate passed versions in the brief time prior to adjournment, the bill was not enacted.

Although there is disagreement regarding the proper solution to our health manpower problems, there is general agreement with respect to the problems, namely:

1. Geographical maldistribution.

2. Specialty maldistribution, and

3. The growing reliance on foreign medical graduates by the United States.

When last year's conference broke up, I was under the impression that health manpower would be one of, if not the first order of, business, by the Health Subcommittee in this session. Therefore, I

am personally disappointed over our delay in moving health manpower legislation.

It is now mid-September and, thus far, we have had only 1 day of hearings. What has our delay and inaction meant?

It means that many health manpower programs have expired and the funding for such programs will not be included in the regulator Labor-HEW Appropriations bill, H.R. 8069, which, incidentally, was reported by the Appropriations Committee to the full Senate on September 10.

Without authorizing legislation, the health profession schools, unless corrective action is forthcoming, will be forced to operate under a continuing resolution which is estimated to reduce capitation grants to such schools by approximately 25 percent of the level for the previous year. This reduction, keep in mind, results not from a positive decision by Congress to reduce capitation grants, but as the result of our inaction. Indeed, both the Senate- and House-passed versions last year continued such grants.

A specific example of a program endangered by our inaction is the Physician Shortage Scholarship Program.

Authored by me in 1972, this program provides scholarships for individuals who agree to serve in shortage areas. Priority in awarding such grants is given to students from the shortage areas. Because of vetoes of Labor-HEW bills, and subsequent operations under continuing resolution, this program was not funded until last fall. Over 1,000 students applied for these scholarships and nearly 400 were awarded.

Now, since the authorizing legislation has expired, \$2 million, which was appropriated last year, will not go to this fall's freshman class, as former HEW Secretary Weinberger promised me, but rather to fund second-year scholarships for last year's recipients. And this is the fate of a program which a HEW contracted evaluation said embodied "more of the characteristics specified in our conceptualization of a model program" and for which these evaluators urged congressional funding. Right now, the funds are appropriated, but without authorizing legislation, 400 freshmen students who would have been committed to serve in shortage areas will be lost.

As a member of the Budget Committee, I am also forced to make an observation regarding the potential serious consequences of our delay. Before doing so, I would note that the Budget Act contemplates the completion of authorizing legislation by June 30 of each year. This is in recognition of the need for timely appropriations if funds are to be used most efficiently and effectively, and that timely appropriations are dependent upon timely action by the authorization committees.

While this particular provision is not operational this year, the problems presented as a result underscore the wisdom of such a requirement and the need for earlier action by this committee.

However, the main issue I want to raise with respect to the budget process and our delay on health manpower legislation is that there is likely, later this year, to be a budget crunch as the Congress attempts to live within its spending targets.

The Budget Committee did provide some flexibility, "cushion" or "slush funds," as it is variously referred to, in some functional areas,

such as health. The problem is these funds will be on a "first enacted-first served" basis. When this flexibility is utilized, it could spell disaster or defeat for these programs who are waiting at the end of the line for enactment.

So, Mr. Chairman, I believe the Senate-passed legislation last year addresses each of our health manpower problems. It could, in my judgment, if reported, be enacted overwhelmingly tomorrow by the Senate.

Under the Beall-Taft measure, 3,500 students would have been committed to serve in shortage areas. We have lost them, and we must bear in mind that their loss must, in many instances, be a continuous or life-time one, in the case of the physician who stays in a shortage area.

I want to emphasize to the chairman that although I believe the Beall-Taft measure is both effective and equitable I remain ready to work with the committee in achieving a workable and responsive manpower bill. I would also underscore my strong belief that the country and the health professional students and schools need and are entitled to an early decision by us. It is time—indeed past time—when we should have enacted health manpower legislation.

I ask unanimous consent that a copy of my introductory remarks on S. 1357, the bill's summary, and my floor remarks of last year be printed in the record.

Senator KENNEDY. It will be so included.

[The material referred to follows:]

[From the Congressional Record—Senate, Mar. 26, 1975]

HEALTH MANPOWER AND SHORTAGE AREA ASSISTANCE ACT OF 1975

By Mr. Beall (for himself, Mr. Taft, Mr. Domenici, Mr. Hollings, Mr. Packwood, and Mr. Young) :

S. 1357. A bill to amend the Public Health Service Act to revise and extend the programs of assistance under title VII for training in the health and allied health professions, to revise the National Health Service Corps program and the National Health Service Corps scholarship training program, and for other purposes. Referred to the Committee on Labor and Public Welfare.

Mr. Beall. Mr. President, along with Senators Taft, Domenici, Hollings, Packwood, and Young, I reintroduce the "Health Manpower and Shortage Area Assistance Act of 1975."

This is essentially the same measure that was overwhelmingly adopted by the Senate on September 24, 1974, by a vote of 81 to 7, with the exception of technical and minor changes. However, we increased the scholarship assistance for the disadvantaged from \$5 million to \$20 million. This increase was the result of additional information provided during the conference deliberations.

Mr. President, one of the major disappointments of the last Congress was its failure to pass health manpower legislation. While both the House and Senate passed separate legislation, we were unable to reconcile the differences prior to adjournment. As a result of the Congress failure to enact health manpower legislation, our initial impact will likely be delayed an entire year. Thus, the proposed changes in health manpower may not have a real impact until the entering class of 1976.

The result of this delay is that we will have lost some 3,500 students who would have been committed under the Senate-passed bill to practice primary care in medically underserved areas. In addition, our failure to act last year may mean that some 400 scholarships under the physician shortage scholarship program for which \$2 million had already been appropriated and for which Secretary Weinberger made a written commitment for the funding of scholarships for the incoming freshmen in the 1975-76 school year may not be available. This program incidentally, according to a report prepared for HEW, was described as embodying "more of the characteristics specified in our conceptualization of a model

program." I am naturally hopeful that these scholarship funds will be made available to the new class as promised.

Mr. President, the need for enactment, of health manpower legislation is critical. There is broad agreement that such legislation is needed, and needed now. When national health insurance is enacted, the effect will be to increase the demand for medical manpower and services. If we do not respond to these manpower problems, the predictable result, as occurred under medicare, is that prices will increase substantially. So any delay on our part, such as already has occurred, will only mean we are likely to repeat the experiences of medicare.

Mr. President, the House Health Subcommittee has already completed its work on health manpower and I certainly hope that the Senate will give health manpower the priority attention which it merits by taking early and favorable action on this measure.

I ask unanimous consent that a brief summary of the main provisions of the bill and a copy of my floor remarks of last year, be printed in the Record.

[The text of S. 1357 appears in Volume 1 of these hearings.]

There being no objection, the material was ordered to be printed in the Record, as follows:

BRIEF SUMMARY OF THE MAIN PROVISIONS OF THE "HEALTH MANPOWER AND SHORT-AGE AREA ASSISTANCE ACT OF 1975"

I. Main Provisions:

A. Requires health professional schools as a condition of federal capitation (institutional grants to schools) to reserve 25% of their enrollment positions, or the national need, for individuals who volunteer and agree to serve in a medically underserved area. Schools are also directed to give special consideration to qualified applicants from shortage areas. If HEW Secretary determines 25% is adequate to solve the maldistribution problem, he can increase capitation grants by 10% to any school which volunteers to reserve 50%.

B. (1) Students volunteering to enter the reserved positions would be entitled to one of two federal scholarships depending on whether the student wanted to serve in the National Health Service Corps or as a civilian practitioner of medicine or dentistry under the Health Services Shortage Area Scholarship Program.

(2) An individual electing to serve in the federal Corps would receive a scholarship of approximately \$9,200. An individual opting to serve as a civilian doctor would receive a Health Services Shortage Area Scholarship of \$6,000. Recipients of both programs would be required to serve in a medically underserved area one year for each year of scholarship, except that the minimum period served would be two years. If the individual fails to carry out his commitment, he or she would be required to pay twice the federal assistance plus interest.

C. Management grants, not to exceed \$25,000, would be authorized for participants of both scholarship programs to assist them in setting-up their practice in medically underserved areas. However, individuals electing to practice as a private practitioner would have to extend his period of obligated service one year for a \$12,500 grant and two years for a \$25,000 grant. The management grant, in the case of the Corps members, is made to a public entity and no additional service obligation is required.

D. Capitation grant levels to the various health profession schools in general are kept at current authorization levels. Capitation grants for schools of medicine would gradually decline over a three year period (\$2,500—\$2,350—\$2,200). However, the reduction could be averted if 50% of the graduates of the medical schools enter primary care post-graduate training. Capitation levels over a three year period for the various health profession schools are as follows:

- (1) to make primary care comparable to other major clinical specialties;
- (2) dentistry—\$2,200 (\$800 for dental auxiliaries);
- (3) veterinary—\$1,650;
- (4) pharmacy—\$800;
- (5) podiatry—\$800;
- (6) optometry—\$800;
- (7) public health—\$1,100; and
- (8) schools with graduate programs in health care administration—\$1,100.

E. Medical schools, in addition to a one-time enrollment increase, would also be required:

(1) to make primary care comparable to other major clinical specialties;

(2) to have either family medicine, postgraduate positions equal to 10%, 15%, and 20% over the three years of the bill, or comparable primary care equal to 35%, 40%, and 45% over the same period.

(3) to limit the number of foreign medical graduates (FMGs) in affiliated postgraduate training positions to 40%, 35%, and 25% respectively over the three year period.

F. Health professional schools, other than medicine, would be required to meet specific conditions to receive capitation grants including a one-time enrollment increase.

G. Combines Special Project Grants and Health Manpower Education Initiative awards of present law into one section entitled: "Special Project Grants and Contracts." \$75 million is authorized annually for carrying out twenty-two specific projects, including projects for:

(1) curriculum improvement;

(2) interdisciplinary programs;

(3) training programs for health professionals; and

(4) training programs to educate specialized physician assistants to assume some of the roles fulfilled by residents in hospitals.

H. Authorizes \$20 million annually for a Disadvantaged Assistance Program.

I. Authorizes \$140 million over three years for grants for training, traineeships, and fellowships in family medicine and comparable primary care.

J. Provides for a new \$15 million, three year program, "Community-based Health Manpower Education Program," to develop community-based primary care training centers throughout the country in order to promote:

(1) the training of graduate and undergraduate medical schools, nursing, and physician-extenders;

(2) regional systems of continuing education to upgrade the skills of inner-city primary care providers; and

(3) greater integration of regional health personnel and education institutions.

K. Foreign Medical Graduates—Bill conditions the admission of alien physicians to the United States upon the findings that the alien:

(1) has passed the same examination as required for graduates of United States Medical schools; and

(2) has demonstrated competence in oral and written English. In addition, there has to be a finding that the admission of the alien will not lead to a surplus of practitioners in a specialty area or geographical area in which there is no present or projected need.

II. Provides for a three-year extension of Allied Professions Program.

III. Costs: Approximately \$2.1 billion over a three-year period.

[From the Congressional Record, Sept. 23, 1974]

HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT OF 1974

Mr. BEALL. Mr. President, unlike previous health manpower legislation which has come to the Senate floor with a bipartisan and unanimous recommendation of the Committee on Labor and Public Welfare, S. 3585 has been reported by a severely divided committee.

Voting against reporting the legislation were Senators Eagleton, Hughes, Dominick, Taft, and myself. I believe that the strong and bipartisan opposition in committee will be converted to a bipartisan majority on the Senate floor to reject the extreme legislation and the excessive spending levels recommended by the committee.

S. 3585, among other things, would in effect, establish a domestic draft. It would condition Federal capitation grants to health profession schools on such schools requiring as a condition of admission, each student, regardless of whether he received any direct Federal assistance, to enter a contract requiring such student to serve in a medically underserved area.

Second, S. 3585 provides for Federal licensing and relicensing of all doctors and dentists. While these licensing provisions are limited to doctors and dentists, the committee report makes it clear that this is only the foot in the door insofar as Federal licensing is concerned and the committee has the same in mind with

respect to the other health professions. The committee's intent in this regard could not be clearer and I quote from the committee's report:

"The Committee also . . . believes that problems respecting the licensing of health professionals is not limited to physicians and dentists. At an appropriate time the Committee intends to further this matter."

Third, S. 3585 provides for Federal control over the types and location of residencies.

Finally, as the administration has indicated, the authorized spending levels are excessive. In this period of unprecedented inflation, we should be exercising fiscal restraint. The over \$5 billion provided by S. 3585 is not the example the Senate should be setting if we are serious about our battle against inflation.

Since the early 1960's, an evolving and growing Federal interest and support for the development of health manpower has been primarily aimed at increasing the aggregate supply of manpower, especially physicians. By any yardstick, we have been successful in that effort. For example, the first year medical school places grew from 8,759 in 1965 to an expected 15,500 this coming fall.

We have found, however, that increasing the aggregate supply alone will not solve our health manpower problems and our goals of providing health care services to all of our citizens.

Now Mr. President, it is easy for the committee with its 20-20 hindsight today to say that not enough or not the right action has been taken. Yet, it is interesting to note that the HEW memorandum which was included in the report and which the committee describes as the best critique of the administration proposal, in identifying the principal thrusts of the health manpower legislation since 1963 did not list, other than enrollment increases, any other major thrust at the maldistribution problem.

I quote from that memorandum:

"Since 1963, the principal thrusts of the programs have been (1) to expand enrollment and output; (2) to alleviate the school's financial distress; (3) to facilitate enrollment of socioeconomically disadvantaged students; (4) to facilitate changes in curriculum; (5) to support training of midlevel manpower; (6) to support new types of training arrangements; and (7) to launch a number of research and analytic studies to better understand the health manpower system. The amount of resources expended on activities (4) through (6) were very modest compared to those allocated on (1), (2), and (3)."

Now that Congress, and almost everyone in the health field—their hindsight is as good as ours—realizes that increasing the aggregate supply alone will not solve our health manpower problems. The drastic recommendations of the committee would lead one to believe, however, that no one else realizes what the committee has discovered and there is no hope for the various segments of the health community to move toward the solution of these problems without the heavy Federal hand and Federal controls.

The minority feels it will be necessary to increase enrollment since we envision reductions in the number of FMG's—foreign medical graduates—because of our recommendations in that area. We do not believe, however, that the primary manpower problems facing the country are numbers, but the kind of physicians—primary care versus specialist—and their geographical distributions—the need to attract more physicians to inner city and rural shortage areas.

OVERALL SUPPLY

HEW recently published a report on health manpower entitled, "The Supply of Health Manpower." This report indicated that in 1970 there were 159 physicians for each 100,000 population—1 physician for every 628 persons—and the physician-population ratio was expected to reach 197 physicians for each 100,000 population by 1980—1 physician for every 507 persons—and 237 physicians per 100,000 population in 1990—1 physician for every 422 persons. These projections would place the United States near the top of industrial nations in terms of overall supply.

As a result of such projections, Secretary Edwards, taking into account insurance coverage and provider productivity, testified that the manpower supply would be adequate to meet our requirements.

Similarly, Dr. Duval, former Secretary of Health, at a recent Institute of Medicine's health manpower conference, observed that last year our physician-

population ratio reached 173 per 100,000—1 physician for every 578 persons—which he said is—

“Approaching the highest of all the nations in the world. But, while nobody knows exactly where the limiting point is, it appears from world experience that there comes a physician-population ratio beyond which the health of the people is not measurably improved by more physicians. In this circumstance, balancing the supply-demand equation depends more on the manner in which medicine is taught and practiced rather than a sheer numerical weight of practitioners.”

Secretary Edwards also warns that—

“A surplus of medical manpower may at first seem attractive but upon more careful examination several undesirable consequences emerge. Because physicians tend to have considerable control over the volume and mix of services they deliver, and the pricing of these services, a surplus of physicians is likely to yield:

“An increase rather than decrease in the total and per unit cost of health services;

“A reduction in productivity, which may affect the quality of care rendered;

“A displacement of other types of health manpower from their roles in the health delivery system—e.g., the physician extender.”

Although gross numbers are important, we must keep in mind the important productivity issues also. Increased productivity is needed in all sectors of our society, but the potential in the health manpower area is particularly promising and the need is obvious in view of rising costs in this field.

PRODUCTIVITY

In the health field, there is growing interest in the development of new roles. Studies indicate, for example, that the physician assistance could increase the physician productivity by between 30 and 70 percent, and with no differences in the outcome for the patients. Since the compensation of a physician extender is less than the physician, the potential for considerable savings is obvious.

Dean Morgan of Johns Hopkins University School of Medicine expressed the following concern, which we share, regarding the effects of S. 3585 on these developments:

“The Kennedy proposal which extends the “carrot” of student loans and capitation grants to medical schools that totally convert to training physicians for the National Health Service Corps will greatly shift the momentum away from developing mid-level Allied Health Professionals . . . It will create an army of physicians demanding physician's compensation who will be doing tasks quite easily delegated to Health Professionals whose services will not be so costly.”

The importance of these developments on the number of physicians needed can be appreciated by Secretary Edwards' estimate that if “annual physicians productivity, as measured by physician visits, were to increase by 1 percent annually for 10 years, over 30,000 fewer physicians would be needed to provide the same total number of visits.”

In addition, last year Congress enacted legislation to encourage the development of health maintenance organizations.

Thus, changes and redesign of our health system are underway. If we load our health system with too many physicians before the impact of these developments becomes more clear, we may delay such developments for decades and at the expense of both greater provider productivity and the taxpaying public.

GEOGRAPHICAL DISTRIBUTION PROBLEM

The major issue and concern in the country is not the overall number but the kind of and distribution of physicians.

There is no question that this Nation has a serious geographical maldistribution problem. This is evident by the AMA 1970 estimate that 132 counties in this country lack a single physician. Obviously there are many more communities without a single or adequate number of physicians. The committee report points out some of the significant differences both among States and within States with respect to physician distribution. Although my State enjoys a good overall physician-population ratio, there are great variations within Maryland ranging from one physician for every 299 persons in Baltimore City, to one physician for every 325 persons in Montgomery County, to one physician for every 2,215 persons in Calvert County, and to one physician for every 3,312 persons in Caroline County.

While no one knows the exact dimensions of the geographical shortage problem, a number of estimates have been used.

The American Academy of General Practitioners suggested a ratio of family physicians of 1 to 2,500 as their intermediate goal. With this ratio the shortage would be under 2,000. Similarly, the National Health Service Corps has found that physicians are used very inefficiently below a certain ratio and will not assign corpsmen to a community below a ratio of 1 to 1,500. Using that criteria, the shortfall would be under 10,000 physicians.

Further, on the international scene, it is our understanding that in England a person joins a panel and physicians are paid according to the number on their panel; 3,500 is the maximum number of individuals allowed on a panel and the average is 2,500. This would result in a ratio of 1 to 2,500. Using the English general practitioners average panel, we would be short less than 4,000.

These numbers and ratios and their implications needed to be examined because some understanding of the "numbers game" is important. We in the minority do not know the exact demand, and neither does the committee, in our judgment. However, we must assume that they are leaning toward the higher numbers or otherwise we are at a loss to understand their drastic domestic draft recommendation.

PRIMARY CARE

The continuing decline of the primary care physician is a matter of major concern. There is general agreement that we have inadequate numbers of primary care providers.

In 1950, the general practitioner comprised approximately 50 percent of all physicians. In 1972, they accounted for only 15 percent. Medical specialists in other fields, particularly internists and pediatricians, have partially compensated for the reduction in the general practitioners. Even when we combine the general practitioners, internists, and pediatricians, their total accounts for only one-third of all physicians and not all would be practicing primary care. Furthermore, based on current distributions of residencies, the proportion of physicians in primary care will fall to about 30 percent.

Senator KENNEDY in introducing S. 3585 estimated there was a shortage of 50,000. Now the Senator said during his statement that we have a shortage of 130,000. An HEW study indicated the number of physicians required to meet specific practitioner ratio criteria on a county basis. Based on this study, a physician shortage of 30,000 has been used. This number results from using the ratio of one physician per 1,000 population on the following HEW chart:

1:2,500	-----	960	1,841
1:2,000	-----	1,396	3,774
1:1,500	-----	1,982	9,470
1:1,200	-----	2,340	17,679
1:1,000	-----	2,591	29,413

With respect to these numbers included in the chart, it is important to keep the following points in mind. Presently we have approximately one physician for every 578 persons. Kaiser Permanente, an HMO which many believe makes optimum use of health manpower, requires an overall ratio of only 1 to 1,000. The Kaiser ratio might lead one to conclude that if they make optimum use of health professionals, and they require only one physician per 1,000 population, this would be a valid ratio and our physician requirements would be approximately 30,000.

While one could jump to that conclusion, we must step back and examine these numbers, for the 1 to 1,000 ratio includes all physicians, both primary care and specialists. However, since it is the primary care physician we are really talking about in connection with the maldistribution problem, it is important to examine the physician-population ratios for primary care.

It is our understanding that Kaiser employs a ratio of primary care practitioners of 1 to 1,520 and this, according to the earlier chart, reduces the physician requirements to less than 10,000.

Yet, a general consensus seems to be that about 50 percent of our physicians should be trained in primary care.

The shortage of primary care providers is evident by:

"The number of patients going to hospital emergency rooms for care that can be performed in a doctor's office;

"The number of rural areas without doctors; and

"Difficulty and long lines, even in suburban areas, in finding a family doctor."

What this shortage of primary care providers means is:

"Primary care is often done by specialists and this usually means higher fees, many more tests and expensive equipment;

"Increased hospitalization; and

"The neglect of preventive care which often results in more serious illness and expensive equipment."

There is little question that a serious imbalance exists between specialists and primary care providers and this must be reversed.

FOREIGN MEDICAL DOCTORS

Another serious national health manpower problem is the Nation's growing reliance on Foreign Medical Graduates (FMG's): This too has been an area of concern to me. In a 1973 speech at the dedications of a health facility I stated:

"Another aspect of the manpower picture which I find intolerable is this Nation's reliance on foreign medical schools to train over 15% of its total supply of doctors, while at the same time, 15,000 American young men and women are denied a place in medical school. Of the 11,032 additions to the medical profession in 1970, 27.3% was attributable to foreign trained medical doctors. In Maryland for the same year, foreign medical graduates made up 37.7% of the additions to the medical profession. This Nation simply should not tolerate the drain of talent from less affluent countries while at home, half of the qualified applicants are rejected by our medical schools. Both our parochial pride and interest in these American students, as well as the medical needs of other nations, argue that we move to reduce or eliminate this heavy reliance on foreign trained doctors. While this cannot occur overnight, it is the direction in which we should be moving."

The number of FMG's entering the United States comes as a shock when one first encounters these statistics. It has been estimated that the number of FMG's entering the United States in the past 2 years ranged from 80 percent to 115 percent of the number of total U.S. graduates. HEW says the higher estimate results from double counting and places the number around the 80 percent figure. In any event, the number is too large. Further, in 1973 almost one-half of the new licensees in medicine were FMG's. FMG's raise the following serious issues:

"Quality;

"Fairness to American students;

"Fairness to foreign nations; and

"Whether FMGs have discouraged or delayed this Nation from fulfilling its own health manpower needs and the development of new manpower roles which might have resulted but for the large influx of a ready source of doctors."

It was generally felt that many, but not all, FMG's skills are inferior to graduates of medical schools in this country. A recent task force of the American Association of Medical Colleges—AAMC—stated:

"FMGs underline the process of quality medical education in this country and ultimately pose a threat to the quality of care delivered to the people. . . . It is generally acknowledged, although not proven that the medical care rendered by some FMGs is a poorer quality."

In addition, the FMG's score lower and have higher failure rates on objective type examinations.

Also, concern has been expressed regarding the difficulties many foreign medical graduates have with the English language. This is most bothersome for as the minority report states:

"Medicine requires adequate communication between the patient and the physician and among the health team participating in life and death struggles when time does not allow for translations or misunderstanding."

FMG's are also a concern in view of the large number of qualified Americans who desperately desire to become physicians but are unable to do so. The profession of medicine is personally self-satisfying and financially rewarding. This opportunity should not be denied so many Americans while we permit so many foreign medical graduates to enter our country.

In addition, there is a serious concern regarding the so-called physician drain on the exporting nations. The magnitude of the problem can be seen from the following statistics:

"There are more Thai-trained physicians in New York than are providing care to Thailand's twenty-eight million rural population;

"South Korea, which has only one physician per 13,000 citizens, recently has been losing 10 percent of its physicians annually to the United States; and "Approximately one-sixth of the medical graduates of Iran come to the U.S. annually."

Finally, FMG's seem to act little differently than our own graduates. Like their American counterparts, a great majority of FMG's specialize and practice in suburban areas. Only 10 percent of FMG's are in general practice. To the extent FMG's are given priority to come into this Nation and to enter a specialty which is already overcrowded, they obviously only aggravate the specialty problem.

Now, I will discuss the recommendations of the committee majority and the substitute which will provide an alternative to the Senate—an alternative that will work, an alternative that will rely on a voluntarism rather than coercion, and an alternative the taxpayers can afford.

DOCTOR DRAFT

The reported bill would in effect create a domestic draft for graduates of health professions schools. As previously stated, this is accomplished by conditioning the Federal capitation grant to the various health professions schools on such school requiring all students, even if the student did not receive a cent of direct financial assistance, to enter an agreement to serve in medically underserved areas.

I know the committee is sensitive regarding the characterizing of S. 3585 as proposing a health professions or doctor-draft.

Well, Senator EAGLETON in his views called the proposal a "doctor draft." The AAMC, which represents the Nation's medical schools, said S. 3585 "was tantamount to a draft." Senator HUGHES, in his additional views succinctly and eloquently described the mandatory service provisions as follows:

"I cannot agree, however, that we should attempt to solve these problems through legislation which would bar a person from entering the profession of his choice unless he submits to an agreement giving the Government the power to designate the position and location in which he must serve for two years. In my view, this system would constitute a draft of the members of a particular profession for a purpose not shown to be essential to the military defense of the Nation.

"I doubt if the floor manager would like any better the description given the proposal by the Pittsburgh Press in its September 16 editorial commenting on S. 3585:

"To some this may sound like social planning. A more accurate label would be involuntary servitude."

Mr. BEALL. We who oppose the reported bill do not believe that a Congress which has helped end the military draft and a Nation and its youth who are making an all volunteer armed services work will support a civilian draft and lottery—and a new bureaucracy to administer it—for the health professions. In addition, the Association of American Medical Colleges—AAMC—has indicated the committee's approach is unconstitutional. I ask unanimous consent that this legal memorandum be printed in the RECORD following my remarks.

Beyond our strong personal and philosophical aversion to this compulsive approach, we believe it does not make sense, nor is it required, to resort to a draft. The volunteer approach will work; we say this for a number of reasons.

First, applications for medical schools are running about three times the number of acceptances. Since it is expected that some 15,000 students will be entering medical school this fall, this means some 30,000 applicants, many very qualified, were turned down. The great desire of American students to enter medical school is further evidenced by the fact that over 3,300 Americans have left this Nation to study in a foreign medical school. Can anyone seriously doubt that many students would not volunteer to serve in shortage areas if they were able to be admitted to medical schools? Not only do we believe they will, but the evidence on similar programs can lead us to believe they will. We cite:

First. The growing interest and response to the National Health Service Corps. Four hundred professionals are now assigned to over 200 communities and an additional 250 physicians will be assigned to shortage areas by next July. The Corps received over 1,000 applications but were able to award only 345 medical scholarships.

Second. The Armed Forces Scholarship program, which was designed to provide the military with adequate numbers of doctors, now that the draft has

ended. This too has worked and is oversubscribed. There were 5,000 applicants who applied for the 2,911 medical scholarships which were awarded.

Third. The Physician Shortage Scholarship program, which was enacted in 1971 but only recently implemented and which gives priority to individuals from shortage areas offers similar evidence. Although the regulations were just issued in May, over 1,000 applications were received, but only 395 scholarships could be awarded.

Thus, for the aforementioned scholarship-for-service programs, there were over 7,000 applications. We were, however, able to award only 3,651 scholarships, leaving some 3,000 applicants who wanted to serve but could not because scholarships were not available.

The substitute we propose will assure more primary care physicians will serve in the rural and urban shortage areas of this Nation. And we will accomplish this goal without a health professions draft.

Under our substitute, medical schools will reserve 25 percent of their first-year class or the national need, whichever is lesser, for individuals who want and agree to serve in these shortage areas—in medicine, such service must be in primary care. These students would be entitled to a Federal scholarship in return for service in shortage areas. If an individual refused to carry out his commitment, he would be required to pay back twice the cost of his assistance plus interest.

With 25 percent of their class committed to serve in primary care, medical schools will be required to give increased emphasis to primary care.

The evidence suggests that today's student will respond to our volunteer approach. Dr. Price, president of the American Academy of Family Physicians, has this to say about today's medical students:

"Today's medical students are extremely interested in becoming a family physician since our discipline provides an outlet for their deep social interest and a means for them to deal with patients on a one-to-one basis."

Medical schools are seeing this interest reflected in their students. As Dean Dennis of the University of Maryland tells us, his school has witnessed "a renewed interest in primary care with between one-third and one-half of the students interested in primary care in contrast to a very few 10 years ago."

I believe that students will not only make such a commitment but they will honor it. Mr. Phil Aaron legislative affairs chairman of the Student American Medical Association—SAMA—told our Health Subcommittee that such programs "tied to a service commitment can be effective." He cited studies indicating the success some States have had in getting students to serve in shortage areas. In Kentucky, for example, 98 percent of these physicians fulfilled their service obligation and some 90 percent of these 200 students remain in rural Kentucky today.

In addition, the University of Illinois has an important and successful program designed to increase the number of doctors in rural areas.

This program seeks to identify individuals who are motivated to practice in rural areas. Over 75 percent of the students carried out their commitment.

An evaluation of this program by the medical school concluded:

"The results of this evaluation of the MSLFB program in Illinois should encourage methods of admissions committees of professional schools. Faced with an abundant number of qualified candidates for admission, committees would like to make choices which will reflect the needs of society rather than small differences in academic credentials."

Mr. Aaron of SAMA was right on target when he criticized existing program structures and screening of students saying:

"There was little selectivity in the screening of loan applicants. A large percentage of our nation's medical students are from urban areas. We feel it is illogical to expect a large percentage of physicians-in-training to select areas of critical need in which to establish their practices if, in fact, these environments are different to the environment in which the student has been exposed. One just cannot grasp the positive features of a rural or inner city practice from a Greyhound bus."

Our substitute is designed to secure greater selectivity. Individuals will have come under our program because they wanted to and elected to serve in medically underserved areas not because they were conscripted to serve. I ask the Senate which individual, the draftee or the volunteer, is more likely not only to serve but hopefully also remain in the medically underserved area.

A disgruntled draftee is not apt to exhibit the dedication and comment that is needed. A disgruntled draftee will likely do his time and get out. As a matter of fact, he will probably be departing at the very time his experience makes him most effective for the citizens. Certainly this is not conducive to good care and its continuity for our inner city and rural citizens.

Based on this year's freshman class enrollment, our substitute will begin producing 3,750 physicians annually for service in shortage areas. Over the life of the reported legislation, over 18,750 primary care physicians would be committed for shortage area service. This number would be adequate for a physician population ratio in the earlier chart, excepting only the very lowest ratio. Over the 3-year bill, as provided in the substitute, over 11,250 students would be committed to serve in shortage areas.

SPECIALTY MALDISTRIBUTION

The reported bill would also establish a 22-member HEW Secretary appointed National Council on Postgraduate Physician Training and create 10 regional councils to regulate the types and locations of residences. The councils are designed to deal with the specialty maldistribution problem and also the FMG problem.

That, incidentally, Mr. President, is 440 people. So we are not adding considerably to the Federal payroll.

We believe these provisions are unnecessary for a number of reasons.

First, they are duplicative of existing law. The 1973 social security legislation directed the National Institute of Medicine of the National Academy of Sciences to study house staffing and support. If we are going to mandate studies, we should at least take a look at the results before we legislate a course of action.

Second, it is premature, both because of the study and also because of the progress being made in the private sector. The Coordinating Council on Medical Education has called for increased training in primary care and also the various specialties are today addressing this oversupply problem.

The approach of our substitute and the developments in the private sector will respond to the problem without the heavy involvement of the Federal Government. For the most part, the issue seems to be not enough primary care physicians.

Senator KENNEDY, in introducing his bill, did discuss the growing number in the surgical specialties and cited studies indicating that the "number of surgeons in the United States has a direct effect on the number of surgical operations performed" and that "there are more than twice as many surgeons in the United States as in England and Wales and proportionately more operations are performed" in our hospitals.

In recognizing this argument, we would note it is the same caveat we found with respect to dangers of an oversupply of physicians.

We agree the imbalance between primary care and specialists must be corrected.

Under our proposal 25 percent of the students in medical schools will be committed to practice primary care. There is general agreement that this problem must be faced, but we see this problem as requiring more individuals in primary care which will result in less individuals in the specialties.

Health Secretary Edwards would also place the emphasis on the production of more primary care physicians. I quote from the Secretary's testimony before our committee:

"As I noted earlier, the problem is between primary care and non-primary care specialists. I see little value and much more harm by going far beyond the real problem and introducing unnecessary regulation. The ability of positive incentives to have an impact on primary care training is clearly illustrated in the remarkable growth over the last few years in the demand for and support of Family Medicine residency positions. As you may know, for this coming year, the number of individuals desiring first-year residency places in Family Medicine exceeded the number of available places by approximately 1,000. This occurred at the same time as the number of first-year places increased by almost 50 percent. This encouraging event leads me to conclude that we can achieve a better balance in the distribution of residencies without the total regulatory control required by S. 3585."

We should also keep in mind that the medical school where education is received and the hospital where postgraduate training is generally provided, both tend to emphasize specialization. For the most part hospitals are interested in acute patient care. Added to this is the reimbursement mechanism which generally only covers inpatient and hospital care and this is a further encouragement for specialty training since this enables the funding of postgraduate training programs.

As a result, primary care in general is not a priority for either the medical schools or the hospitals. The reported bill's solution is to regulate everyone. Our solution will be to provide and require that more individuals will enter primary care and thus less will be specializing.

Also, our substitute will result in a greater emphasis by medical schools on primary care and encourage training in primary care settings. Provisions in the substitute designed to do this include.

First. The requirement that medical schools establish an appropriate department or unit for greater emphasis on family medicine or primary care.

Second. The requirement that medical schools increase their family medicine postgraduate training, positions to not less than 10, 15, and 20 percent over the years or primary care residencies to not less than 35, 40, and 45 percent over 3 years.

Third. The establishment of a more community-based educational training program to enable the rotating of undergraduate medical students, and other health professions. It is anticipated that this will result in a major grant in each State.

Fourth. The expansion of the existing grants for training, traineeships, and fellowships in family medicine to also include other comparable primary care, and increasing the funds for this program in the second and third years of the bill by an additional \$10 million to \$50 million.

Dr. Price of the American Academy of Family Practice emphasized the importance of such incentives when he stated:

"At the time of the national intern-resident matching program last April, over 1,900 graduating seniors applied for residencies in family practice. This represents almost 20 percent of all graduates, and it has only been a few years ago that 5 percent or less of the graduates were so inclined. Unfortunately this year there were only about 1,200 first-year openings in family practice residencies available and thus the lifetime services of about 750 potential family physicians were lost to this country."

These 750 family practitioners who were lost to the country probably became specialists. Thus, we believe that the combination of requiring more primary care physicians on one hand and the encouragement of more postgraduate residencies in primary care, on the other, will adequately deal with the problems of not enough primary care physicians and too many specialists.

My State's experience, confirms the national interest in family medicine. The University of Maryland has one of the best programs in the country. At the present time, they have 20 family medicine residencies. There were 60 fully qualified applicants for these 20 residencies in July of this year. The State has approved an increase of the number of residencies to 60 and has appropriated some \$800,000 for the program.

We would also note that although we are concerned with the oversupply of specialists, there is little question that when we have a serious problem, all of us would like to have care by the specialists, rather than generalists.

Specialists will always be needed. Dr. Price of the American Academy of Family Practitioners warned the Health Subcommittee against the overreaction of the reported bill as follows:

"Requiring that all students in any school which receives capitation grants to agree to serve in a medically underserved area might well result in the future production of a health dilemma which is the opposite of what we have today. That is, we might well produce an insufficient number of traditional specialists and super-specialists."

In addition, under our approach for the medical graduates, we would not allow any FMG to receive a priority in admission to the United States if he was going to practice in a specialty which was overcrowded.

In passing we note that the committee, which prohibits HEW from regionalizing for administrative purposes, will allow a HEW-appointed national council

and 10 regional councils to certify residency needs and support. We simply do not believe that the respective States, the various health entities, or the health professions will grant HEW-appointed councils this absolute regulatory power to control residencies without first making certain there is no alternative.

NATIONAL LICENSURE

The reported bill provides Federal standards for licensing and renewal of licensing for doctors and dentists. If the States fail to enact the Federal standards, the Federal standards become Federal licensing and presumably another new bureaucracy will be created to administer them. States would also be prohibited from licensing a physician who did his postgraduate work in a position that was not certified by the national and regional councils, which control residencies.

We believe that national uniformity is a desirable objective in the licensing area. Indeed, this is being achieved as all but two States have adopted the so-called Federation's Licensing Exam—FLEX.

With respect to the issue of relicensure and recertification, we certainly support the need for health professionals to keep abreast of current developments. We, however, have seen little or no evidence to indicate that reexamination is particularly effective. The AAMC has indicated that they had a committee on graduate and medical education studying these issues and they testified that "there is no known measurable effect on a physician's practice as a result of reexamination." While one's intuitive feeling is that such an examination would improve the health professional, there is very little on the record to support such a contention.

Also professional standards review organization—PSRO's—are just getting underway. Presumably, they will be impacting on this problem. The continuous review of a physician's patient-case decision, measured against accepted norms, will result in the identification of substantial deviation from such norms. These deviations then will be brought to the physician's attention and corrected. Also, the professions and the states are also addressing the problem. We received testimony that 22 out of 23 specialty boards are seriously considering recertification. In addition, two states have enacted laws requiring relicensure. Further, the American Board of Internal Medicine will offer a voluntary recertification exam this fall; the American Board of Family Practice will require a recertification for all its members in 1976, the Board of Ophthalmology is considering a voluntary, self-assessment exam in 1975, as is the Board of Thoracic Surgery; in addition, the American Board of Surgery plans mandatory recertification for all those certified after September 1, 1975, on a 10-year cycle. One reason advanced for the Federal licensing provision indeed it is a congressional finding of the reported bill, is that licensure practices adversely impact physician mobility. Yet, Carolynn Steinwald, in a literature review of the factors influencing distribution and location of physicians, said:

"It has been hypothesized that licensure practices of individual states poses a barrier to interstate mobility and thereby affect nationwide distribution. This variable has been investigated and analyzed by Sloan, Benham et al., Rimplinger and Steele, and Scheffler with negligible results. Conclusions of all of these studies indicate that the effect of licensure practices on distribution is not significant."

We intend to delete the licensure provision.

TESTIMONY AGAINST LICENSING

The Senate should be aware that there was little support given to the Federal licensing provisions. One could not gather this from the selective presentation of the testimony and other information in the Senate report. For as one reads the report one would feel that Dr. Derbyshire, Secretary-Treasurer of the New Mexico Board of Medical Examiners, was an advocate of Federal licensing. One could make this impression from the excerpts of his testimony found on page 111 and from the partial inclusion of his testimony on page 130. However, the committee omitted a rather significant part of his testimony which indicates that Dr. Derbyshire does not favor Federal licensing:

"In regard to specific provisions of this bill, which I was asked to testify on, I am aware of the fact that I will put myself on the defensive no doubt in opposing

national licensure, and there is certainly plenty of room for argument and you might think that I have spent most of my time arguing in favor of national licensure, and I am in favor of national standards, of uniform standards, and the mechanism is there with the States already having it. The main thing they have to do is put it into effect, as far as I can see, and they are gradually doing this.

"I think that it is going to take a little more persuasion to have them reform the law, but I think that they are going to get around to doing it. Of course, I would like to point to the Tenth Amendment to the Constitution of the United States, a copy of which I happen to have with me, and you are all familiar with it, so I will not bore you with that, but this is a matter of State's rights, and my legal counsel and several judges by credence have definitely stated that this is the police power of the States and it has not been delegated to the Federal Government."

Similarly, Dr. Plemme of the George Washington Medical Center stated:

"Now, I am a bit startled by the language of the bill, in that it empowers the Secretary to establish a system of examination when in fact Dr. Derbyshire has pointed out the establishment and wide acceptance of FLEX."

In addition to the testimony presented to the committee, the AAMC in a memorandum to the committee stated:

"The objective of national uniformity is already being met through standard use in nearly all States of the FLEX exam for licensure . . . AAMC lawyers have challenged the constitutionality of precluding licensure for failure to comply with these conditions."

Secretary Edwards testified to the committee as follows:

"We agree with you in terms of the need of uniformity among States, and in terms of licensing requirements. But basically we believe that the licensing per se is a State responsibility."

In short although this is not the picture that emerges from the report, there is little, if any, support for the licensing provision of the reported bill. This is an area of State responsibility. National uniformity is being achieved and the mechanism for achieving uniformity among all the States exists with the FLEX exam. Our substitute will delete the licensing provisions.

FMG PROVISIONS

What about the foreign medical graduate?

The reported bill uses the mechanism of national licensing to assure the quality of the foreign medical graduate and the regulation of postgraduate training through the control and certification of residencies to reduce the number of FMG's coming to our country. It would do the latter by relating the total number of certified positions to the expected number of graduates of U.S. medical schools. Beginning in fiscal 1976 the total number of positions could not exceed the number of U.S. graduates by more than 40 percent, and gradually this would be reduced to 25 percent by July 1, 1978.

On the other hand, our approach utilizes the mechanism that is appropriate for the Federal Government to deal with the FMG problem; namely, the immigration laws. Our substitute's provisions with respect to the FMG's are direct and effective and will deal with the issues raised as well as recognize a need for flexibility during a transitional period. The majority of FMG's are, of course, aliens and of necessity enter this country under procedures determined by the Immigration and Nationality Act of 1952, as amended. It is our contention that the direct and appropriate way to assure that alien FMG's meet certain quality standards is to specify these standards in the Immigration and Nationality Act as conditions for their admission to the United States.

Not the least of the advantages of this approach is the certainty that we are legislating in an area of undisputed Federal jurisdiction. Quoting from an 1892 U.S. Supreme Court decision:

"It is an accepted maxim of international law, that every sovereign nation has the power, as inherent in sovereignty, and essential to self-preservation, to forbid the entrance of foreigners within its dominions, or to admit them only in such cases and upon such conditions as it may see fit to prescribe (*Ekiu v. U.S.*, 142 U.S. 651, 12 S. Ct. 336, 35 L. Ed 1146 (1892))."

The courts have consistently ruled that the power of Congress to prescribe the grounds for exclusion of aliens is virtually unlimited.

Mr. President, section 704 of the Beall-Taft-Dominick substitute requires that alien physicians who are not entering as relatives or refugees must satisfy certain basic requirements in order to be eligible for entry. They would be required to pass the same examination that American students must take, and to demonstrate competency in oral and written English. In addition, their entry would be contingent upon a finding that—and I quote directly—

"The admission of the alien will not lead to a surplus of practitioners in a specialty area or geographical area in which there is no present or projected need."

Provision is made for a temporary waiver of these requirements on an individual basis where the Secretary of Health, Education, and Welfare finds that there is a critical need for the alien's services, and no other reasonable alternative exists. An alien physician receiving a temporary waiver would be required to be enrolled in an appropriate training program to remedy existing deficiencies to enable him to pass the required examination.

The new requirements, which would go into effect on July 1, 1975, would apply primarily to alien physicians who are basing their application for entry on their occupational qualifications, rather than on other possible grounds for eligibility such as close family ties or refugee status. It is also limited in applicability to aliens applying for immigrant status—that of aliens lawfully admitted for permanent residence; as opposed to aliens applying for temporary admission as nonimmigrants. This latter category includes tourists and other temporary visitors, as well as "J" exchange visitors, the nonimmigrant visa classification most frequently used by FMG's. However, at the point at which a nonimmigrant attempted to adjust his status to that of immigrant, he would be subject to our provision unless he qualified under the relative categories.

I would like now to assess briefly the probable affects of this amendment in terms of the number of alien physicians it would cover. According to statistics provided by the Immigration and Naturalization Service—INS—the majority of the 7,119 alien physicians who entered the country as immigrants in fiscal year 1973 entered on the basis of their occupational status, though not, as might be expected, under the occupational preferences.

A total of 2,006 entered under the Eastern Hemisphere third and sixth occupational preferences, while 3,646 enter under the Eastern Hemisphere non-preference category. Our amendment includes aliens falling within each of these categories.

Of the approximately 1,500 other entries, 393 entered under the numerical limitations of the Western Hemisphere and would be covered unless they were—and quote—

"The parents, spouses, or children of United States citizens or of aliens lawfully admitted to the United States for permanent residence."

The remaining 1,100 entries fell primarily into the following categories not covered by our provision: Eastern Hemisphere relative preference—517, refugees—32, and immediate relatives—510. In short, we are satisfied that this provision provides the necessary coverage without conflicting with the intent of our immigration law to promote family reunification.

Our amendment is, in effect, a labor certification provision for alien physicians, and would apply to the same classes of immigrants now covered by the labor certification provision. Under the labor certification provision—section 212(a)(14) of the Immigration and Nationality Act—certain specified classes of intending immigrants must obtain certification from the Secretary of Labor to the effect that there are not sufficient workers in their occupations at their intended places of residence, and that their employment will not adversely affect the wages and working conditions of workers in the United States who are similarly employed. The provision's applicability is limited to intending immigrants from the Eastern Hemisphere who are not immediate relatives or entering under the relative or refugee preference categories, and to intending immigrants from the Western Hemisphere who are not close relatives of U.S. citizens or permanent resident aliens.

The new section 212(a)(15) which our amendment would add to the Immigration and Nationality Act, immediately following the labor certification requirement, differs from that provision in two important respects. First, it would be administered by the Secretary of Health, Education, and Welfare rather than

by the Secretary of Labor, since HEW is better able to make the determinations required. We also exclude alien physicians from coverage under the labor certification provision, in order to avoid duplicative and/or conflicting action by the Departments of Labor and HEW.

Second, and most importantly, the amendment would legislatively prescribe the specific conditions under which the alien physicians may enter the country. At present, this determination is made administratively by the Department of Labor through the Code of Federal Regulations.

In 1967 the President's National Advisory Commission on Health Manpower made the following recommendation:

"The National Board of Medical Examiners provides an objective testing service which should be utilized just as it is for graduates of U.S. Schools. Issuance of an immigrant visa on the basis of Third Preference should be contingent upon satisfactory performance in the examination." Quoted in S. Rept. 93-1133, p. 124).

More recently, Dr. John Cooper of the Association of American Medical Colleges and in testimony before the Senate Labor and Public Welfare Committee:

"I think what one really has to determine: Are those who come in the country qualified? If not, they should not be permitted . . .

"The problem is one has to assure oneself that the professionals we do admit are qualified and equivalent to those we have here in this country."

At this point the subcommittee staff director asked Dr. Cooper if he was satisfied that our present system was working satisfactorily in that respect, and Dr. Cooper's reply was: "No." (S. Rept. 93-1133, p. 139).

The approach suggested by these two statements—both of which were taken from the majority report on S. 3585—is in our opinion the appropriate one for solving the considerable problem posed by FMG's. In essence it is an immigration problem, best solved by an amendment to the immigration law.

COSTS

Finally, we come to the matter of costs. In our opinion, S. 3585 is too expensive. The President has already indicated that the various health measures, including S. 3585, carry too high a price tag, as well as some objective program features. The committee did raise the existing capitation levels for schools of medicine to \$3,250 from the existing \$2,500 level, an increase of approximately 30 percent.

Given the present inflation pressures, as well as the requirements of the health professions schools, I do not believe those increases can be regarded as anything other than excessive and unjustified.

At the present capitation level medical schools are responding to national objectives. As the committee report recognizes their responses to the requirement for enrollment increases was "magnificent." Further under existing capitation level, only 6 out of 114 medical schools are receiving financial distress grants which would indicate that more schools are doing satisfactorily at the present level.

We agree with the President that S. 3585 has excessive spending levels and we urge the Senate to join us in rejecting the inflationary price tag of the reported bill.

Mr. President, in closing, I would like to say that we think the alternative that has just been submitted offers a viable alternative to deal effectively with the problems of maldistribution by geography and by specialty and with the problem of foreign medical graduates. We think it is a more appropriate answer than is that of requiring a national draft of all those who are entering medical school that it would be Federal foot in the door and lead to Federal licensing of all in the health profession. Indeed, the report's language is most explicit on the committee's intent.

Senator KENNEDY. Dr. Cooper.

We welcome you and your associates.

STATEMENT OF THEODORE COOPER, M.D., ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY KENNETH M. ENDICOTT, M.D., ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION, DHEW; ROBERT VAN HOEK, M.D., ACTING ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION, DHEW; STUART H. ALTMAN, PH. D., DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (HEALTH), DHEW; EDWARD MARTIN, DIRECTOR, NATIONAL HEALTH SERVICE CORPS; AND DALE W. SOPPER, ACTING DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH), DHEW

Dr. COOPER. Mr. Chairman, I am pleased to have the opportunity to present to you the administration's view regarding the health manpower proposal.

I have with me Dr. Endicott, the Administrator of the Health Resources Administration; Dr. Robert Van Hoek, Acting Administrator, Health Services Administration; Dr. Stuart Altman, Deputy Assistant Secretary for Planning; Dale Sopper, Acting Deputy Assistant Secretary for Legislation; Daniel Whiteside, Director, Bureau of Health Manpower; and Edward Martin, Director of the National Health Service Corps, and other representatives of the program who will be available for answering any specific and detailed questions that will come up in the course of the discussion.

I have a very lengthy and detailed statement of 67 pages which I would ask be printed in its entirety in the record, and with your permission I would like to begin the dialog by just summarizing the highlights of the administration's proposals as they are outlined in here.

Senator KENNEDY. The statement will be included in its entirety at the conclusion of your testimony.

Dr. COOPER. The statement also summarizes many of the points that you and Senator Beall have made about the nature of the problem, the nature of the previous discussion, the need for action which we all endorse for all the reasons specified both in your statement and Senator Beall's statement.

In order for us to come to grips with this, we would like to propose that the new health manpower legislation continue capitation. We would propose that the capitation continue at \$1,500 per student for medical, osteopathic, and dental schools who are willing to set aside a specified percentage of directly affiliated residencies for primary care or general dentistry, establish and maintain an undergraduate level primary care teaching unit, and set aside specified numbers of first year spaces for students willing to serve in underserved areas if offered a scholarship.

We would propose that capitation for the veterinary schools, optometry, podiatry would be phased out over 3 years, with pharmacy eliminated immediately.

The second part of the proposal would direct itself to the question of financial distress. We would propose continuation for the nonprofit and public health awards limited to 75 percent of the previous year's award.

On the question of construction, we would recommend amendment of the special project authority under title XVI to add authority for primary care teaching space development.

A fourth point concerns the general topic of special projects which we think should encompass the following group of issues:

One: There should be flexibility for the development of family medicine residencies and training;

Two: There should be support of primary care residency training in general internal medicine, general pediatrics, and general dentistry;

Three: We would propose grants to schools for affiliation with the medical, osteopathic, and dental schools, clinical pharmacy and clinical pharmacology, for geriatric interests and the like. We would propose a flexibility to award grants to schools training public health professionals.

Four: We would propose the ability to provide grants and contracts for allied health professional training;

Five: We would propose that authority for grants to support continuing education of physicians and dentists be extended. We would propose grants and contracts that would be based on community-based telecommunications systems to help contribute to amelioration of the problem of geographic maldistribution.

We would propose grants to assist in retraining those foreign medical graduates in the United States to upgrade skills that are necessary for them to meet a standard that all physicians should have before being introduced to clinical practice or service in an institution.

We would propose assistance to the disadvantaged when they get to medical schools in the form of a stipend technical assistance for 2 years preprofessional training and 1 year of professional school itself.

In the area of student assistance, we would propose a small continuing Federal contribution to the schools revolving funds, and the students' repayments should remain available for further loan fund maintenance.

The Office of Education federally guarantees student loan authority should be enlarged to permit up to \$7,000 per year with a maximum of \$25,000 per student.

In the area of scholarships, we would propose consolidation of the PHS scholarship program that should be available to all health professionals where payment would be year-for-year service payback with a minimum of two, or twice the amount borrowed plus interest.

We would also propose that the Department establish a nonstatutory commission which is advisory to the Secretary for graduate medical education. This group would perform analysis of those functions that are necessary to make recommendations to the Secretary in order to insure appropriate specialty balance.

We would propose health manpower innovation development and demonstration grants which were similar to the existing amelioratory, and these grants would be to public nonprofit entities to develop innovative approaches to health manpower education across the whole spectrum that would range from primary care to continuing education problems of the different types.

We would propose that the Secretary set up a national health manpower analysis capability on all health provisions using a contract authority. The data are to be used for national level policy and statutory analyses and program development.

Finally, on the problem of the FMG issue, the Department will discuss the entry status of the foreign medical graduate with the relevant agencies, the Departments of Labor and State.

The Department is in favor of establishing a qualifying examination that would insure that the foreign medical graduate, prior to the time that he embarks on clinical practice, have both the capability with the language as well as the capability technically to meet our standards.

These general points are spoken to in detail in the larger statement, Mr. Chairman. We would be pleased to review the details or answer any questions that you or Senator Beall might have at this time.

Senator KENNEDY. You have obviously given us a summary of your approach to meeting the areas of concern that have been identified by Senator Beall and myself.

Let us be more specific with regard to the kind of assistance that will be made available to the medical school and the scholarship program. How you expect that to work.

What is the obligation of the medical school going to be? Let us focus on the relationship between the contribution of the Federal Government to the medical school and the specific programs you expect to ameliorate the problems of geographic maldistribution and specialty maldistribution.

Would you elaborate on that?

Dr. COOPER. With respect to the geographic maldistribution program, each medical and dental school will be asked to set aside an annually increasing percentage of their first-year places for qualified students who voluntarily agree to practice in an underserved area. Such a requirement would commence at 15 percent in fiscal year 1977, increasing to 25 percent in fiscal year 1979.

Senator KENNEDY. What if they do not?

Dr. COOPER. You mean if no student would be willing to do this?

Senator KENNEDY. Yes.

Dr. COOPER. This would be a condition of capitation for an institution, that if a school could not meet this condition of capitation, the capitation would not be available.

Senator KENNEDY. You mean if they do not meet the 25 percent, then the school does not get capitation?

Dr. COOPER. Yes.

Dr. ENDICOTT. Mr. Chairman, this seems to be an awkward provision, but it is our impression that in reality it would not present a problem to the schools.

The attitude of the students is, I think, quite favorable toward this. The response that we have had, the Department of Defense has had, to scholarship offerings and so on, would suggest this is not an unreasonable requirement, sir.

Senator KENNEDY. I think probably you are right about that.

Senator BEALL. Historically, is it not true that all the programs that have as a condition some sort of service in return for the payment of the fee have been oversubscribed?

Dr. ENDICOTT. Yes, that is true, Senator.

Dr. COOPER. Correct.

Dr. ALTMAN. The Secretary would have the authority to issue waivers where the school had obviously made a good faith effort but had fallen slightly short.

We are looking for two things. There would be scholarship funds available for these students, and we would like to see these students trained throughout the United States and not concentrating, not concentrated in a few specific schools. Therefore, we are asking each of the schools only to set aside these places for them and to show a good faith effort to get them in, and we have no reason to suspect that, in fact, this program will not be oversubscribed.

Dr. ENDICOTT. Mr. Chairman, I have one serious mental reservation about this, and it has been referred to by Senator Beall.

In order for this strategy to work, our appropriations and legislation are going to have to be almost considered in a package. If we are making this kind of offer to students, and then fail to appropriate funds for the scholarships, this is not a workable proposition.

Senator KENNEDY. What about meeting that particular problem by making it an entitlement?

Would you support that?

Dr. ENDICOTT. Sir, there has been no opportunity to discuss this in the administration because this has been a real struggle to come here with this new proposal.

Senator KENNEDY. I am sure it has been.

Dr. ENDICOTT. I am speaking personally, Senator. I really feel strongly enough about this I think that probably it should be an entitlement. We have had a lot of slippage between legislation and appropriations, and I am uneasy on this point.

Senator KENNEDY. Let me ask how much would be made available under the scholarship program? Do you have the current projections?

Dr. KINDIG. Yes, Mr. Chairman.

Senator KENNEDY. Would you please give your name for the record?

Dr. KINDIG. David A. Kindig, M.D., Deputy Director, Bureau of Health Manpower.

Our current projections for this new proposal for authorization would allow on the order of 5,500, 7,500, and 9,500 scholarships in the first 2 years of the act.

Senator KENNEDY. What is that in terms of dollars?

Dr. KINDIG. \$55 million.

Dr. ALTMAN. \$25 million plus \$35 million.

Dr. KINDIG. \$55, \$75 and \$95.

Senator KENNEDY. Million dollars?

Dr. KINDIG. Yes, sir.

Dr. ENDICOTT. The cost per student, Senator, is approximately \$10,000 since it carries some allowances as well as a stipend.

Senator KENNEDY. How do you get the figure of \$10,000?

Dr. ENDICOTT. That is based on our experience with the National Health Corps scholarship program.

Senator KENNEDY. What does it cost currently?

Dr. MARTIN. The stipend award is around \$6,750 per year. The tuition averages about \$1,500 or \$2,000.

I think we are projecting ahead for additional costs. For example, a number of tuition costs are going up. The other fees and support are

marginal. The largest cost is stipend, which represents around 75 percent.

Senator KENNEDY. The current figure is about \$10,000 at the present time and you are projecting how much?

Dr. MARTIN. No, Senator. The projection is \$10,000. The current, I think, comes up to about \$9,100 per student.

Senator KENNEDY. What are the percentages to be set aside each year for the scholarship program?

Dr. COOPER. The percentages would start at 15 percent in 1977; 20 percent in 1978; 25 percent in 1979.

Senator KENNEDY. Where did you get those figures? Why did you start off with 15?

Dr. ALTMAN. We were trying to phase up the 25 percent which we thought would be about the number of physicians that would be necessary to meet our anticipated need.

We recognized that to go from 0 to 25 percent was perhaps too precipitous for some schools, and, therefore, we tried to phase them up.

There is nothing magic in the 15 percent except it is more than half-way there quickly, and then there was a phase in between 15 and 25 percent.

Senator BEALL. Why did you not start with 25?

Dr. ALTMAN. We could, but if we did that, some schools could legitimately say right off the bat, "We just do not have time to move that fast."

It seemed to us, for the good of an orderly transition to a new program, that we not jump in quite that quickly.

Senator BEALL. You have waiver authority anyhow, do you not?

Dr. ALTMAN. We do not stop a school from going to 25 percent right away, but to demand that a school go to 25 percent, where they are now at 2, 5, 8, 10 percent, seemed to be a little precipitous.

Dr. ENDICOTT. Mr. Chairman, I do not think this should be a stickingpoint. There is nothing very magical about the figure of 25.

Senator BEALL. We had 25 last year and no one objected to it last year.

Senator KENNEDY. We had 100, and there were plenty of people who objected.

[Laughter.]

Senator BEALL. Does the stipend respond automatically to whatever the pay is for the lowest commissioned rank in the Armed Services?

Dr. VAN HOEK. No, the stipend will be fixed at \$400 per month for 9 months.

Senator KENNEDY. What about the buyout problem? Could you tell us a little about that? You referred to that a bit earlier. I think you said it was two times plus interest, something like that.

Dr. COOPER. Twice the scholarship amount received plus interest.

Senator KENNEDY. Do you have an opinion on the constitutionality of that? Are you satisfied with that?

Dr. ENDICOTT. It is a steep buyout, that is certainly true. It would be about \$14,000 for each year of assistance to buy out of the thing.

Dr. COOPER. We do not have an official opinion.

Senator KENNEDY. Could you give us just a note on that?

Dr. COOPER. We will get a position on it.

Senator KENNEDY. Very good.

[The information to be supplied follows:]



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The Honorable Edward M. Kennedy
Chairman, Subcommittee on Health
Committee on Labor and Public
Welfare

United States Senate
Washington, D. C. 20510

MAR 11 1976

Dear Senator Kennedy:

This letter is in response to your request for our opinion as to the constitutionality of the scholarship "buy out" provision of S. 2748, a bill "To revise title VII of the Public Health Service Act, and for other purposes."

In substance, we believe that the scholarship "buy out" provision (proposed section 721(e) of the Public Health Service Act) is a civil recovery which Congress has the power to enact.

Proposed section 721 would provide for the establishment of the Health Service Scholarship Program, which is designed to provide scholarships to medical, osteopathic and dental (MOD) students in exchange for service in the Public Health Service, other Federal health service, or in a health manpower shortage area. The scholarships would be awarded for periods of two to four years in an annual amount of \$3600, plus tuition and other reasonable educational expenses. Upon completion of professional training the scholarship recipient would be required to perform one year of service for each year of scholarship support. Should a scholarship recipient fail to complete his professional training or, having completed his training, fail to complete his service commitment, he would be required to "buy out" of his service obligation by paying to the United States twice the amount of the scholarship assistance multiplied by the proportion of the service not performed, plus interest (proposed section 721(e)(1)). However, should he fail to serve as a result of circumstances beyond his control, the "buy out" requirement would be waived. Further, the Secretary of Health, Education, and Welfare could, in his discretion, provide by regulation

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for waiver, partial waiver, or postponement of the service commitment for any other good cause (proposed section 721(e)(2)).

Whether the civil recovery of proposed section 721(e)(1) is classified as "liquidated damages" or as a "civil penalty" is not significant in determining its constitutionality. Rather, the test is the excessiveness of the statutory recovery. Only where the recovery is so excessive so as to be totally unrelated to the damage inflicted is the statute unconstitutional. The "buy out" provision of the bill clearly falls within the boundaries of constitutionality as delineated by the case law.

For example, in Overnight Motor Co. v. Missel 316 U.S. 572 (1942), the Supreme Court dismissed a challenge to the constitutionality of section 16(b) of the Fair Labor Standards Act, which provides for double recovery of unpaid overtime compensation. The Court upheld the statute on the grounds that the wrongful retention of a workman's pay by his employer "may well result in damages too obscure and difficult of proof for estimate other than by liquidated damages." (at p. 583)

Similarly, in Rex Trailer Co. v. United States, 350 U.S. 148 (1956), the Supreme Court upheld a \$10,000 civil recovery against a company which acquired five vehicles from the Federal government by fraudulently using the names of persons possessing veteran priority rights. The statute permitted a \$2000 recovery for each fraudulent act. The government did not allege specific damages and the Court said "it is the function of liquidated damages to provide a measure of recovery in such circumstances." (at p. 154)

The government's remedy under proposed section 721(e)(1) is not excessive. The United States is damaged insofar as it is deprived of physicians and dentists to carry out programs that are supported by the Department of Health, Education, and Welfare. The amount of the damage is the expense above the service salary that otherwise would have been paid to the program participant which the United States would have to incur in order to secure other medical personnel to

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provide equivalent services. Given the everchanging and constantly rising costs of medical services, any fixed estimate of equivalent services is necessarily outdated in a very short time. The government's recovery of twice scholarship support discounted by actual service performed is a conservative measure of damages.

We hope that these views will be helpful in your consideration of S. 2748.

Sincerely yours,

/s/ St. John Barrett

St. John Barrett
Acting General Counsel

Senator KENNEDY. What else can you tell us on capitation?

Dr. COOPER. The other proposed conditions attached to capitation would be linked to increasing primary care training, and all medical schools would be asked to establish an administrative training unit in primary care, and have a high proportion, eventually 50 percent, of their affiliated residences in primary care.

Senator KENNEDY. That sounds like the bill that the administration vetoed about 5 years ago.

Dr. COOPER. I did not read that bill.

[Laughter.]

Dr. COOPER. These conditions were, of course, included in recognition of the importance of the medical school environment on speciality choice of the student at this point in time.

Senator KENNEDY. Before we leave that, would all the medical schools be required to develop a unit?

Dr. COOPER. As a condition of capitation, yes, sir.

Senator BEALL. Did you define primary care?

Dr. COOPER. Yes, sir.

I pointed out that these would be general internal medicine, general pediatrics, and general dentistry included as well, and family medicine. I suspect in some cases a case could be made for some additional ones which we would be willing to explore.

Dr. ENDICOTT. Mr. Chairman, I think it would be accurate to say that there is divided opinion as to precisely what role should be in primary care for the internist, for the pediatrician, and under some circumstances other areas such as the obstetrician, the gynecologist, the pharmacologist.

Although the family medicine residency training program has gained rapidly in popularity, it is our feeling that we should continue to allow a natural evolution adjustment of the major specialties to this problem without focusing on just the one family medicine residency program.

The departments of medicine and pediatrics have been somewhat slow to respond, but there appears to me to be enough developing here that it should be strongly encouraged and not pin everything on just the family medicine approach.

Senator KENNEDY. We would like to get a look at this. I think our concern has been the primary care function. I think this is what you are talking about.

Dr. ENDICOTT. Yes.

Senator KENNEDY. This is what we are interested in, and I think you probably do have to have some flexibility in areas you have mentioned here. I do not think we have any problem in that area.

Dr. COOPER. In one other area, in capitation, I would point out that we would also propose some increase in enrollment in the dental schools, because there is a problem here in aggregate numbers that we will want to consider as a condition of capitation. But we would like with that also a waiver authority if it proves in individual cases that a case can be met that this is not possible in an institution or that it poses a particular hardship.

Senator KENNEDY. Let us just take that thought and carry it on a bit.

What is your feeling about the need to decrease our reliance on the FMG's? What is the administration going to do about that?

Dr. COOPER. We think there will be an increase in enrollment of American doctors with the plans of the institutions as they are going forward now, but, of course, we would not prohibit institutions from expanding their classes.

We think from our projections that what the expanded need might be, even taking into consideration perhaps expanded forms of insurance, reduction of the FMG inflow, that this increase which may be as much as 12 percent could be met by 1980 over this same time frame with the program as currently operating and as proposed in this bill.

Dr. ENDICOTT. Mr. Chairman, I think we ought all to recognize that we have been in a period for the past decade playing what might be called catchup ball, and we are making pretty good progress in this.

If we were to take advantage today of the number of competent young Americans who want to go into medicine, and we could accommodate them and assist them, we would, within a decade, be in an overproduction posture.

It would be wonderful; it would be kind of a miracle, if we could do this temporarily and at low cost and then drop back to a somewhat lower level.

The extent to which the university apparatus is prepared to improvise, to expand, to take advantage of the opportunity, and then taper back, is a big unknown, but that is the kind of game we are playing here.

All the projections that we have would suggest that, say, by 1990, we could safely cut back to maybe 2,500 FMG's a year, which is about what we have always had.

There are talented young people in the system who would really like to get into this game, but how to accommodate them quickly in the system, and then bring it back to normal production is a very expensive thing unless the universities were, as I say, willing to sort of improvise here and take more than they can eventually handle.

Senator KENNEDY. Senator Beall.

Senator BEALL. I just wanted to make a comment.

I think sometimes we mislead ourselves when we talk about pure health manpower ratios. I think we just should not talk in terms of numbers of doctors but the total number of people who are delivering the services. We should frame this issue in terms of total health manpower needed to provide the level of care and visits that are needed in our society, and not just talk in terms of exclusively of the number of doctors we might have as a proportion of our population. If we do, we may preclude ways of improving productivity considerably.

Dr. ENDICOTT. Yes, sir, although it is about to be slipped over here in this rapid presentation of a new position, there is one thing which I think we have all tended to minimize, and that is the shortage of dentists.

It is clear that something on the order of 40 percent of our whole population is getting far from adequate dental care, ranging to none at all, and the dental profession has been regrettably quite resistant to expanding the supply.

Of course, there is another problem. The uneducated people in this country do not take advantage of dental care when they should. But this is another area which is badly overlooked.

Senator BEALL. The point I am making is we talk purely in doctor ratio and we are precluding some other approaches, the doctor's assistants and dental assistants, those people who are capable of delivering care.

Dr. COOPER. I would agree with you, Senator, on that, and I think the professions have to enter into a very serious discussion very soon along with us on the question of a definition of role in order to give the States guidance in licensure development from the standpoint of the whole spectrum of practical operating to effective use of the whole range of health professionals in this regard.

Senator KENNEDY. Could we talk a bit about the specialty distribution?

Dr. COOPER. Yes, sir.

We recognize this is an important problem. For that reason, we do propose as a condition of capitation, as I have already mentioned, that the specialty emphasis on primary care and its development of primary care atmosphere, if you want to call it that, be a condition of capitation.

I do not need to bring to your attention the impact that has on the attraction of students in here.

Senator KENNEDY. Just before leaving this, what do you expect the medical schools to do?

Dr. COOPER. To set up an administrative unit that can be identified as responsible for the development of the teaching program in this. We expect them also to be able to develop a meaningful ambulatory primary care capability.

This has requirements that go beyond this legislation which I think we will have to discuss with the Congress in perhaps another setting, but one of the problems that the institutions have here in developing and maintaining a capability is a will to become self-sufficient in this area from the reimbursement standpoint.

So this particular problem cannot be viewed in a vacuum as only the educational legislation itself. The attractiveness of this particular area requires that these kinds of residency programs compete for the students and for their attention and for the reimbursement of a faculty in the same way that the other residencies do.

I think we expect the schools to take some initiative in establishing the focus around which this can be done, but we have to face the fact that their maintenance and their vigor will depend upon a continuing mechanism of support while the whole tenor of American medicine changes to a more ambulatory primary care tempo.

Dr. ENDICOTT. Mr. Chairman, in addressing the specialty maldistribution problem, I think we have tended to try to put too much responsibility on the medical school and expect it somehow to solve this problem.

It is clearly not under the control of the undergraduate medical school system, and the profession has recognized this and appointed a coordinating committee, of which I am a member. I attended a meeting in Chicago just yesterday.

The question of influencing the specialty mix, it seems clear to me, must be addressed jointly by the profession and by the Federal Government. There is no way I can see that an individual State government can get this done because they can move across State lines and get the residents they want.

There is at hand, or will be at hand, with enactment of national health insurance, the kind of leverage that will be needed, and this is through the reimbursement mechanism which, in the end, pays for residencies.

Dr. COOPER. Mr. Chairman, on page 27 through 33 of the prepared statement, the text carries the proposed activities for an appropriate Federal role in trying to participate in this.

This is the special project grant authority that would speak to family medicine residencies training, training in primary care, grants to schools of the affiliated health professions to participate, training of public health professionals, allied health professionals, physician extenders.

These are detailed on those particular pages.

Dr. ENDICOTT. There is an additional thing, Dr. Cooper, which is item VI in our outline, "Graduate Medical Education Commission," a nonstatutory commission advisory to the Secretary to develop analytical functions and make recommendations which could then be enforced through the reimbursement mechanism to bring about a reduction in the total number of training slots offered, so that it is more in balance with the requirements, and to influence the mix of training slots offered so as to put pressure on the system to drive more people into primary care.

Senator KENNEDY. How are you going to do it? You are familiar, Doctor, with the fact that we have had different approaches on it under the bills. The one that passed last year gave that power to the Secretary of HEW; under the Rogers bill, it was given to the CCME.

I am just wondering how we are going to do it. I do not think what we need is another study. We know what the problem is. I do not doubt that it is complex and involved and there are different kinds of interests that have to be considered, but we know the nature of the problem. I do not question that some of these steps that you have outlined earlier are going to have some impact on it. But the fact remains that we have to give some kind of authority, responsibility, accountability, to get this job done.

Dr. ALTMAN. Senator, there are really three parts. We have come down fairly strongly on this problem. On the one hand, it is the question of getting students interested and trained in primary care at the undergraduate level. The number of special projects speak specifically to that.

The second area is to get financial support to the medical schools so that they can run these affiliated residencies, as we talked about the last time we testified. There is a serious reimbursement problem; hospitals do not get reimbursed for the predominantly ambulatory family practice and primary care resident services as they do for the specialties because of the way our third party insurance system works.

Third, we are saying over time most of our residences are going to be affiliated. We are already approaching close to 95 percent. We

are going to require that schools over time phase up to 50 percent of those affiliated residencies in primary care. We want to insure that students who have received exposure to primary care while undergraduates will find primary care residencies. So these three initiatives, we think, will address the problem.

Where we have had differences, however, with both the Senate and the House has been on the level of detail in telling the medical schools not only 50 percent, but broken down by subspecialties. We do not think we have the knowledge to do that either in the short run or long run.

That is why we ask, in addition to these three things, for the Commission, but I hope you do not view this as simply another study. We have come pretty far.

Senator KENNEDY. May I just come back to this point because I think that is a good analysis.

What we want to know is what is going to be the amount of aid and assistance to the school. How much are you talking about?

I think that is going to be some kind of indication of whether that is going to be a meaningful commitment on point 3. Over what period of time are you going to phase in the 50 percent, and how are we going to take steps which prohibit that unaffiliated 5 percent from growing to 50 percent?

Let us take point 2 first. What are you talking about in terms of assistance to the schools? What kind of financial commitment?

Dr. ALTMAN. We are trying to work within the President's 1976 budget. The President feels an obligation to maintain that thrust.

We have redistributed the 1976 money, and we just have a tentative proposal, and we would hope you will accept that the dollars are tentative—all the dollars we have talked about.

We are talking about a total commitment to special projects of slightly over \$125 million, in fiscal year 1977 with a significant proportion of that—about \$50 million—going to support of family medicine and primary care residencies, but again, I want to stress the tentative nature of this.

In future years, as the economy improves and the capacity for us to see a more favorable budget changes, we are looking for increases, but the 1977 budget in its exact form is still being worked on.

Dr. ENDICOTT. I would again want to reemphasize that working simply with the medical schools is not addressing the heart of the power structure. The medical schools do not control the residence even in their own schools. These are in the hands of specialty boards at the national level, and the individual medical school is powerless to control what is approved in the way of residencies.

Furthermore, if you get into family practice and primary care, we have to change the training sites away from these university hospitals into a different kind of training setting. Some of the schools are beginning to do this in a very impressive way.

I spent a week looking at the WAMI system in the Northwest where family practice residencies are training spread out over four States and small communities where they are really learning family practice.

We are fumbling a little bit; frankly, and, as Dr. Altman said, we do not know exactly what the costs are going to be, but I think we are here today with a positive proposal which can get us somewhere.

Dr. COOPER. With respect to your other question, Senator, we do propose a rather steep phase-in of that requirement on capitation in order to insure progress in this area.

In our proposal, the detail is like 77/35 percent; 78/40 percent; 79/50 percent.

We also feel that the requirement for the authority for the data capability would give us the avenue for monitoring progress which makes us an effective partner with CCME or with the rest of the educational apparatus to keep on top of the problem to see what can and should be done in further dealing with the important problem, especially maldistribution.

Finally, I want to say that despite the frustration that we have had in developing physicians and immediate resolution of all the problems, it is my perception in visiting and discussing with appropriate groups the significant progress that is being made right now in appropriate steps in dealing with the specialty maldistribution problem.

Several of the highly specialized areas are beginning to eliminate from their approved residencies in appropriate positions. They are beginning to relook at the structure of their residency programs in order to make sure that the specialty area contributes appropriately as it should to the development of the family physician and the primary care physician.

In practical terms, that means what you take into a first-year residency is now being geared in significant amount to deal with the appropriate development, background, and training of the primary care of family physicians so that the specialties are conscious of their responsibility to revise both their numbers and also their impact on the mix, both by entering discussions about limitation, but also their contribution to primary care training itself.

Dr. ENDICOTT. There is one more thing. Mr. Chairman, which potentially can get us quite a lot of mileage. This is the new health planning legislation which will give regional and State bodies a voice in not only the Federal educational funds in health manpower that are spent, but also the State funds. So if they do their job of assessing what they really need in the community in the way of health manpower, at long last there may be some leverage to get it.

Dr. COOPER. Then, finally, I would set aside that some areas would not be able to have the necessary facilities, the kinds of resource and training that has to be also comfortable, the atmosphere setting, and we have to propose the means to do this as well.

Senator KENNEDY. Do I understand that their receipt of capitation is contingent on this?

Dr. COOPER. Yes, sir.

Dr. ALTMAN. Yes, sir.

Senator KENNEDY. This is very encouraging.

What is your reaction to trying to put some kind of ceiling on the number of residencies?

Dr. COOPER. At this point in time, I do not think we have the wisdom to arbitrarily set a ceiling. I think if we are trying to go through a transition, we will actually hurt the primary care in that sense.

Senator KENNEDY. So if you go this route, you do not see the wisdom or the usefulness of granting further kinds of authority to either HEW to specify what is going to happen—

Dr. COOPER. I think we would have a working leverage from several areas that I think will be very effective.

Senator KENNEDY. You do not want any more authority?

Dr. COOPER. No, sir.

Senator BEALL. Doctor, in our bill last year we had management grants available to help these people set up a practice in the area of up to \$25,000, recognizing you just cannot send a doctor out and say, "Go ahead and practice." You have to give some assistance.

Did you go into that in your legislation?

Dr. COOPER. Maybe Dr. Van Hoek could comment in detail and I could comment after that on the philosophy of it.

Dr. VAN HOEK. With regard to the special preoperational grants, Public Law 94-63, which extended the National Health Service Corps for 1 year through 1976, included authority for preoperational grants up to \$25,000.

It has been our experience that such preoperational grants are a very valuable mechanism for helping develop the community and the practice setting for the arrival of physicians, dentists, and other health manpower.

At the time of our previous testimony on the legislative proposals, we recommended grants not to exceed \$20,000 because our general experience has been that we need less than \$10,000. It averages around \$4,000 to \$5,000 in most communities.

Dr. COOPER. In principle, we do recognize the importance of creating an environment. You just cannot put the doctor in a setting, isolated intellectually, socially and technically for the facilities he needs. This is not a risk that can be taken independent of community development.

As Dr. Van Hoek has said, we do think it would be appropriate for us to help to contribute to that, but we are concerned with the extent to which that should be done, and the extent to which one would insure the physician in his social setting as well as his technical setting.

There have been proposals oriented to this which address a very important problem, and we do think some action in that area is appropriate for us to include.

Senator KENNEDY. Could we go to the licensure provisions?

Dr. COOPER. Yes, Senator.

Senator KENNEDY. What is your sense about this? We have talked a bit about it—in my opening statement—we talked about the particular kinds of problems that we see on this.

What are your views in terms of being able to set some minimum standards that would be more or less accepted universally across the country?

If the States would want to set additional standards in terms of protections, you could tell them they could. But the difficulty is getting some uniform minimum standards.

What really is the problem in getting some uniformity in terms of minimum standards?

It seems to me that we have come to grips with some of the really tough problems. It does not seem that this should be nearly as difficult.

Dr. COOPER. In one sense, it is more difficult, Senator, because I think it is the question of the extent of the control of the function by the Federal Government of essentially a State function.

I take no issue at all with you on the question that the American public ought to be assured that a licensed physician in one State means the same standard of quality as any place in the United States. I think some degree of success has already been accomplished through this State system in achieving this.

I feel that the State should remain the regulator of licensure, and I would think that the appropriate way to do this is to facilitate the mechanisms by which the individual States can get the necessary information to bring their own hospitals into modern conformance.

I do think there are many suggestions that could be made to States on how to address the current problem, several that you mentioned in your opening statement—the question of sanction, the question of the use of their powers to eliminate physicians who do not stay abreast or do not perform continuously or who perform incompetently.

States have begun to revise their laws. I would suspect that somebody here at the table could give you a number of how many States are actively considering this type of revision and how many States are considering some common utilization of examination practice which assure this kind of initial standardization.

Dr. ENDICOTT. Mr. Chairman, there has been developed through the cooperation of several State Medical Licensure Boards more or less a uniform approach that is called the Flex Examination, which undertakes to address the problem from an examination standpoint.

I think we should all face up to the fact that our current system of medical licensure is out of date. It is an acronym, and we have actually superimposed another system of regulation on it.

What happens, in a nutshell is that quite frequently, still during the normal training period, a recently graduated physician takes a State Board examination and is licensed to practice any kind of medicine that he wants to, and it is a license almost for life.

This is at a time when he is still in formal training. When he completes his formal training, the expectation of the profession are that he will limit his practice to a narrow area, not to the entire practice of medicine.

A number of specialty boards are moving voluntarily in the direction of requiring that he redemonstrate his competence after a period of time so that the profession itself does not really have to go along with this idea of a universal lifetime license.

This is a mess, and it will take the "wisdom of Solomon" and 50 States working together, along with 50 specialty boards, somehow to come up with a solution to it.

I am not proposing that we should plunge in and try to solve it tomorrow but, clearly, we are licensing too soon, too broadly, and too long.

Dr. COOPER. I would like to be excluded from that. I am not sure that I share Dr. Endicott's total enthusiasm for the scope of that problem, but clearly I think progress needs to be made in this, and I think we are seeing some of it right now.

Senator KENNEDY. How many of the professional organizations actually—besides the primary care, the family physicians—have a continuing education program?

I must say they came up and testified about its importance. And they did it with an eloquence and with a rationality that I think defies the other specialties to do so too.

I am just interested in the period of the last year or so, whether any of the other specialists have done it.

Dr. ENDICOTT. I cannot answer that for sure.

Dr. COOPER. Several have initiated assessment programs—but you are asking beyond that, I believe.

Senator KENNEDY. The view that we had of the legislation was to have each of those specialties set up, just for themselves. Just ask them to do it. And then, after a period of time, to have an evaluation of it.

We are not saying we think it ought to do X, Y, or Z; just let them do it and give us the benefit of evaluation of it over a period of time.

It seems to me that is much like a light tap on the wrist. I myself think personally it ought to be stronger. I do not see how they can complain when we propose that kind of action.

Dr. ALTMAN. I wonder if I could just put in a word of caution.

The concern that some of us have deals with the balance between the legitimate Federal role of assuring standardization across the country and how much control we give to individual specialties to set up monopoly control on their own numbers.

You have to be a little concerned, I feel, about what that would do to the cost of medical care on the one hand and access to services on the other.

We could take a good thing and move a little too far.

Senator KENNEDY. That is why we gave it to HEW.

Dr. ALTMAN. We do not quite want it.

[Laughter.]

Senator KENNEDY. So the job does not get done. We do not want it, we do not want the specialties being monopolistic.

Dr. COOPER. Senator, we would accept monitoring the system and reporting back and making such an evaluation.

Senator KENNEDY. That is good.

Let me ask you this.

In your June 1975 report on the question of standards, you have said, at page 135, "In developing uniform national [not Federal] standards both for initial entry into the health professions and for periodic demonstration of continued competence, the PHS approach would achieve the outcome of the uniform national standards based on competence to perform."

That seems to me a wise observation. I am trying to carry your own words on through to a legislative end.

Would you go this far?

How about having HEW develop minimum standards and offering grants to the States which agree to use the standards?

It could be very modest. You would not be putting a requirement on the States to do it. Just make it voluntary. But put a little carrot there to get some States to do it, to see if we can get some States to do it over a period of time. And then when we come around to renew this legislation, we can ask you for an evaluation of whether this has been helpful.

Dr. COOPER. Senator, it seems a very attractive general approach, but I am concerned that the camel's nose gets into the tent.

Senator KENNEDY. We were doing so well this morning. [Laughter.]

Dr. COOPER. I would counterpropose again that we monitor it and that we, in our conversations and our other activities with the groups—

as I am sure they are represented behind me—understand the importance of this, do evaluate the progress the next time, monitor it and assess whether we need to do something more firm at that time.

Senator BEALL. Speaking of monitoring, some States now have relicensing or reaccréditation procedures.

Has any comparison been made between States which have these procedures with the ones that do not to determine whether they are better able to identify bad apples, whatever that might be?

Or is there any relationship with the number of malpractice suits or any other measure to compare one State with the other?

Dr. COOPER. I do not know as to the evaluation at this point, Senator. I think it is one of the things that naturally needs to be made. I think the experience itself of those States will be far enough along very soon to see what impact that has, and that the derivative of that is what impact it has on the equality of care, which is, of course, much more difficult. I think we are cognizant of the need to try to address this in a responsible way.

Dr. ENDICOTT. I think when Senator Kennedy pointed out that only 12 licenses were lifted in a year, that tells the story that the licensing thing cannot be addressing the malpractice problem.

Senator KENNEDY. As you know, 26 or 28 licensing boards do not have the power to suspend a license even if they find malpractice; it is only on conviction of a felony or drug abuse.

It seems to me if we could offer some funds and see which States would take it. And then do an evaluation of it. The next time we consider this legislation we would know whether it makes any difference.

It seems to me it is a small camel's nose under the tent, and I would hope my colleague would be willing to listen to this.

Senator BEALL. Do you want to talk to the FMGs?

Senator KENNEDY. Yes, I think that we should go on to the FMG question.

Dr. COOPER. On the question of FMGs, we think the primary question is quality, and we endorse the idea that we take steps to try to insure the quality of the FMG.

The discussion begins on page 37. We support the development of a single qualifying examination for all physicians who are entering hospital training programs where they will have some responsibility for patient care.

We propose to convene appropriate organizations and groups for the development of such an examination.

The existence of such an examination would introduce into the physician training experience a way to determine, for United States and foreign graduates alike, suitability for the years of graduate education. Because this examination is not yet established and because immigrant physicians should be expected to meet standards of U.S. medical graduates in provision of care in the United States, it is proposed that the Department will continue the most appropriate screening examination for FMG's.

There has been a wide number of different proposals, and I think a decision could be made on that while a new single examination is developed.

With the question of entry itself, we will be willing to begin discussions with the Department of Justice and State on the appropriate mechanisms to address that aspect of the question.

We would also propose, as I mentioned in our special project grants, the provision of authority to provide capability, to provide the necessary support training, to prepare the FMG who does not meet the appropriate level of standard.

Senator KENNEDY. Quite clearly, we are not intending to develop discriminatory standards to keep the FMG out.

Dr. COOPER. Certainly not.

Senator KENNEDY. What would be an appropriate screening examination? I know you considered the question of the part I and part II of the National Boards. Do you have any views on that?

Dr. COOPER. There are some on the staff in the Department who view part I and part II as an appropriate examination. I am not convinced that this is fair at this point in time.

I would opt out for what I just testified to, the development of a single examination which allows the assessment of those aspects of performance for all people who are going to enter clinical practice to be undertaken.

Senator KENNEDY. How long is it going to take to develop that examination?

Dr. COOPER. I have been assured by Dr. Endicott and staff in their discussions with the National Board and others that this can be done rather expeditiously. I do not have a specific time.

Dr. ENDICOTT. Two or three years.

Senator KENNEDY. Two or three years?

Dr. ENDICOTT. To develop it and validate it.

Senator KENNEDY. When will you start to give it?

Dr. ENDICOTT. Sir, I cannot answer that. I do not know precisely how far along they are with the development of it, but clearly one would want to test a thing to see whether we are getting on the right track or not.

I think 2 or 3 years is reasonable. The problem of what to do in the meantime, I think, could be addressed rather simply to negotiations between the Department and the appropriate boards, because the questions that are now offered in the ECFMG examination are actually supplied by the National Boards of Medical Examiners which provide parts I and II.

They know this testing game pretty well. I think the ECFMG examination could be made more rigorous—it is a negotiable thing.

As Dr. Cooper said, which I am satisfied we could work out and provide reasonable time to develop a new approach, and I would like to emphasize that what we are talking about in terms of qualifying examination is an attempt to get away from simply measuring cognitive skills and measure actual practical ability. It is a real challenge to develop this kind of examination.

There should be more practical examination in it. It should not all be written. We are talking about a serious enterprise in the technology of examination.

Senator KENNEDY. You are concerned about parts I and II?

Dr. COOPER. I think at the level we have asked the people to take it, the detail in part I, in particular, might not be actually assessing what we need to have at that point and recall.

Dr. ENDICOTT. There are probably many of us in practice today who would have some problems with part I.

Dr. COOPER. There are others who have suggested only part II.

As a point of equity here, only 27 schools require passage of both parts for graduation, and another 53 only require that they take it. So I would be reluctant to just automatically assume that particular examination fits the objective that we are trying to accomplish.

Senator KENNEDY. What do you think we ought to do in the meantime?

Dr. COOPER. Although I do not have statistics to validate it, I have seen reports in Science magazine and elsewhere—in personal conversations—that the specialty residencies themselves are being more selective in the criteria that they are using for entrance into specialty training.

They are prompted by this not only by discussions, such as this, but by the perception that the prime medical graduate was inappropriately prepared, had language difficulties, and entered into the residency prematurely, and was not passing the examination.

So I think the whole effort reached at the specialty residency programs is going to have a most positive influence. I would also be willing to urge the Department in HRA in their discussions with the examining developers of the examinations to move more rapidly in trying to get a date earlier than 3 years.

Dr. ENDICOTT. Mr. Chairman, I think you made a very important point in connection with the equity, and that is if we are going to continue to draw on foreign medical graduates and admit them into the system, then it seems to me equity requires that whatever examination we come up with for them, our own graduates should be expected to pass before they enter into providing services in a residency position.

Senator KENNEDY. Of course, they do. Do not 90 percent pass the Boards?

Dr. ENDICOTT. But, you see, we have really relied mostly on a graduation from an American medical school, a credentialing that has mostly to do with the medical school and their passing their grades in medical school. They are not required to take State Board examinations to begin an internship.

Senator KENNEDY. I understand that 90 percent pass the Boards.

Dr. COOPER. That is a fact, but it is a voluntary idea. In fact, they do have that kind of screening, and when the committees and the people responsible for the programs review their selections, they have this kind of information available to them.

Dr. ENDICOTT. We rely for our own graduates on quality controls of the schools. For the others, we cannot do that, so we substitute an examination, and the equity of the thing suggests we ought to come up with an examination that we can give to all of them.

Dr. COOPER. I would also like to underscore your point for the record, Senator. I am always concerned about the question of quality of training foreign medical graduates are poorly trained, the inference that all foreign medical schools are not very good.

I would like to state for the record there are some excellent institutions and systems abroad that perhaps some of our physicians, if they wanted to go abroad, would not pass their examinations either.

So I think that that is not the issue that we are trying to discuss here, but I want to make sure that we all recognize that many distinguished leaders of American medicine—physicians and educators—have been trained in that foreign medical graduate system and have served with great distinction.

Senator BEALL. I think you can supplement that, Doctor, by pointing out there are areas in this country where very high quality medical care is being delivered by foreign medical graduates who have gone to areas where graduates of our own medical schools would not have gone. I know there are some areas in my own State where that is the case, and this has been true in my own area of the State.

We rely on foreign medical graduates to deliver the care.

Senator KENNEDY. The question is really what we are going to do until the time when the new test is in place. Whether there is anything that we ought to do in the meantime.

Perhaps you can give some thought to that.

Dr. COOPER. I will give thought to a practical way of dealing with this, Senator, and again I would think that our serious commitment is to monitor the system and the requirement to report back to you on it, which will give us the important leverage.

Senator KENNEDY. We might just deal with the immediate situation and what is going to happen in the transition period.

Senator BEALL. In spite of the fact that there are excellent foreign medical schools and excellent foreign medical graduates, there still remains somewhat a problem.

Does your proposal contain a requirement that they be able to speak English?

Dr. COOPER. I suspect that the intent would be that they do. I think that a facility with the language is a very important part of the practice of medicine.

Senator BEALL. In the proposal we had last year, we suggested that they be able to pass the appropriate tests, and I think perhaps you might make a distinction between an appropriate test and an ideal test.

Dr. COOPER. Yes.

Senator BEALL. It seems to me that 3 years is a long time to design an appropriate test, even down at HEW. [Laughter.]

Perhaps while we are striving for the ideal, we can come up with an appropriate one.

Dr. COOPER. We will try to expedite. As you know, the life of an Assistant Secretary is pretty short.

Senator BEALL. In the legislation we had last year we had a waiver provision.

Are you suggesting that HEW's Secretary could waive some of these requirements if it were in the national interest to get more foreign medical graduates in order to make sure we have an adequacy of delivery of medical care?

Does your proposal speak to waiver requirements?

Dr. COOPER. It does not at this point in time. We will be willing to consider this.

Senator BEALL. You do not know whether you consider it desirable or undesirable?

Dr. COOPER. In principle, I think that kind of flexibility is a useful thing.

Senator BEALL. We also required that there be a limitation on FMG's coming into an area where there is a surplus of doctors.

In other words, in some areas in this country, some specialty areas are overstocked, if that is the proper word. We limited the foreign medical graduate to those areas of practice where there is a need.

Dr. COOPER. I would not favor that as a statutory feature of law, Senator. I think there are other means to deal with that, and that would be very difficult to administer.

Dr. ENDICOTT. I would like to make an additional point there.

This relates particularly to the foreign medical graduate who is coming here on an exchange visa to receive training, to go back to his own country.

I think we ought to permit him to go to the best place in the country to get such training, whether there are too many doctors there or not, and there are probably too many doctors in those places.

Senator BEALL. Of course, many of them would like to stay here.

Dr. ENDICOTT. That is another thing that you may consider later. The exchange visitor visa failed in its initial intent. It is being used as just an additional route to get into the country.

Senator BEALL. On that subject, should he be allowed to go where he wants to go or should he go where his country wants him to go? Because he may want to study a specialty where there is not a need in his country.

Dr. ENDICOTT. I think—this is just a personal opinion—that his country should be consulted. Probably the Department of Health, Education, and Welfare should be willing to take some means of assuring that he is going to get the training that he needs, and then he ought to go back.

Senator BEALL. It seems to me if our purpose is to be of assistance to these people, it should not be for the benefit of the individual but for the benefit of the people in the country where they are living and, therefore, I should think the emphasis should be on what his country wants rather than on his personal preference. After all, the reason for his being here is to assist his country in developing quality medical care.

Dr. COOPER. That was the original conception under which the program was initiated, and we should try to follow its intent, yes.

Senator KENNEDY. I was very interested in listening to my good colleague talk about having a medical student do what his country wants him to do rather than what he wants to do—that is what I would have liked to have done in my bill last year.

[Laughter.]

Senator KENNEDY. That was what we were trying to do last year.

Let me ask you this. I would like to get your estimation of the shortages of manpower in terms of how many doctors are needed to bring all of the State economic areas up to the 1 doctor per 1,000 ratio?

Dr. Cooper, could you comment on this, or would you prefer to submit it?

I would like to give you some specific questions about the numbers of shortages and in which areas. We could do that, and also we would like the urban areas as well, because I think we want to find out in terms of evaluating the percentages that we talk about in the buildup, and to a great extent that depends on what the needs are.

I think we have some questions both in the urban and rural areas, and you can make that a part of the record.

[The information referred to follows:]

SAMPLE

Full report available upon request
to Manpower Analysis Branch, OPD, BHM

BHM/OPD/MAB
7/29/75
Report No. 76-12

PREFACE

This report contains selected data from the Area Resource File for each State Economic Area in the United States arranged by State. The data include total population, proportions of rural, nonwhite, and SMSA population, per capita income, rate of aid to dependent children, number of medical and osteopathic schools, physician/population ratio, number of general hospitals and beds in relation to population, and number of approved intern and residency training programs. Most of the column headings are self-explanatory. ADC indicates 1973 aid to dependent children. The city size code is as follows (largest city in SEA):

- 1 1 million or more and SMSA
- 2 Less than 1 million and SMSA
- 3 10,000 or more, not SMSA
- 4 2,500 - 9,999, not SMSA
- 5 Less than 2,500, not SMSA

STATE NAME	SFA	# OF CONF COUNTIFS.	1970 CENSUS POP	# OF RURAL POP	# OF NON- WHITE POP	CITY POP	SMSA POP	INC/1000 CITY	ACC/ 100,000 POP	POP GROWTH 1960-70	INCOME GROWTH 1960-70	PC + OC 100,000 SCHOOLS	MD + LD 100,000 GEN	# RELS 100,000 FAMILIES		
ALABAMA	01	05	264	54	14	60	2	2,338	41	15	88	0	71	8	456	0
	02	05	215	70	3	25	2	2,002	45	9	104	0	36	8	216	0
	03	07	400	51	17	54	2	12,219	46	3	85	0	55	12	252	0
	04	07	184	55	27	0	4	2,005	39	4	91	0	50	10	305	0
	05	11	237	73	25	24	2	1,897	51	4	106	0	35	15	372	1
	06	09	179	69	61	0	3	1,833	110	12	115	0	45	10	221	0
	07	03	60	83	40	0	4	1,712	59	1	102	18	30	5	338	0
	08	07	94	67	23	63	2	2,111	37	14	89	42	45	6	342	0
	09	17	333	51	27	0	3	2,070	51	5	122	0	53	19	352	0
	65	01	186	21	16	59	2	3,143	38	59	92	0	50	5	516	0
	70	01	116	26	25	59	2	2,217	60	0	76	0	57	1	416	1
	75	01	317	18	33	59	2	2,419	57	1	62	0	115	6	422	2
	80	01	169	17	36	99	2	2,556	34	1	70	0	116	7	408	1
	85	01	45	44	46	99	2	1,833	11	4	97	0	13	1	242	0
	90	01	645	12	32	59	2	2,842	46	2	72	1	205	13	573	11
ALASKA	01	01	300	51	21	99	2	3,765	40	0	0	0	54	6	125	0
ARIZONA	01	06	220	66	32	0	3	2,179	74	27	65	0	76	24	647	0
	02	06	232	44	9	0	3	2,353	40	16	62	0	72	15	445	0
	85	01	352	15	6	99	2	2,579	40	32	57	1	264	10	597	5
	90	01	568	7	6	99	2	3,218	52	46	67	0	205	25	443	5
ARKANSAS	01	02	128	46	2	59	2	2,333	13	39	83	0	86	6	570	0

NOTE: Physician data is as of 12/31/73.

Table 1.

Page 1

ACTIVE NON-FEDERAL M.C. RATIOS

8/8/75

NUMBER OF COUNTIES WITH LESS THAN SPECIFIED RATIO, AND NUMBER OF MD'S NEEDED TO BRING RATIO IN EACH COUNTY TO SPECIFIED RATIO, BY TYPE COUNTY, TYPE M.C., AND SPECIFIED RATIO

	Ratios per 100,000 population							
	RATIO 10		RATIO 20		RATIO 25		RATIO 30	
	# CO	# MD	# CO	# MD	# CO	# MD	# CO	# MD
PRIMARY PATIENT CARE (GP, IM, PED, OBGYN)								
COUNTY GROUP 1 -10,000	46	46	152	155	225	238	285	319
COUNTY GROUP 2 10-24,999	33	36	146	186	239	345	373	605
COUNTY GROUP 3 25-49,999	0	0	17	23	47	79	107	211
COUNTY GROUP 4 50,000 or more	1	2	4	14	12	38	26	95
COUNTY GROUP 5 FOL SMSA	1	1	2	6	3	12	4	17
COUNTY GROUP 6 50-499,999	8	13	33	75	40	153	82	288
COUNTY GROUP 7 500-999,999	4	5	13	34	21	65	28	117
COUNTY GROUP 8 1m.-4,999,999	2	2	11	37	24	102	40	270
COUNTY GROUP 9 5m. or more	0	0	0	0	0	0	0	0
COUNTY GROUPS 1-4 Nonmetropolitan	84		319	378	523	700	791	1230
COUNTY GROUPS 5-9 Metropolitan	15	21	59	152	108	332	154	692
ALL U.S. COUNTIES	95	105	378	530	631	1032	945	1922
PRIMARY PATIENT CARE PLUS GENERAL SURGERY								
COUNTY GROUP 1	42	42	135	138	200	212	256	287
COUNTY GROUP 2	23	26	101	130	171	245	271	436
COUNTY GROUP 3	0	0	7	11	18	34	47	91
COUNTY GROUP 4	1	2	3	10	4	21	9	41
COUNTY GROUP 5	1	1	2	6	2	10	3	14
COUNTY GROUP 6	7	11	28	63	49	123	70	222
COUNTY GROUP 7	3	4	11	27	16	49	21	86
COUNTY GROUP 8	2	2	10	26	19	70	25	138
COUNTY GROUP 9	0	0	0	0	0	0	0	0
COUNTY GROUPS 1-4	66	70	246	289	393	516	583	855
COUNTY GROUPS 5-9	13	18	51	122	86	252	119	460
ALL U.S. COUNTIES	79	88	297	411	479	768	702	1315
OFFICE-BASED PRIMARY CARE								
COUNTY GROUP 1	53	53	157	161	231	246	291	325
COUNTY GROUP 2	35	39	154	198	255	371	394	647
COUNTY GROUP 3	2	2	22	32	53	97	120	247
COUNTY GROUP 4	1	2	5	17	12	45	32	120
COUNTY GROUP 5	1	1	2	6	3	12	5	18
COUNTY GROUP 6	11	16	39	86	66	177	92	335
COUNTY GROUP 7	4	6	16	41	24	79	36	151
COUNTY GROUP 8	4	4	17	56	29	207	42	452
COUNTY GROUP 9	0	0	0	0	0	0	0	0
COUNTY GROUPS 1-4	91	96	338	408	551	759	837	1342
COUNTY GROUPS 5-9	20	27	74	189	122	475	175	954
ALL U.S. COUNTIES	111	123	412	597	673	1234	1012	2296

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OFFICE-BASED PRIMARY CARE PLUS GEN.SURG	Ratio 10		Ratios per 100,000 population				Ratio 30	
	# CO	# DR	# CO	# DR	# CO	# DR	# CO	# DR
COUNTY GROUP 1	49	49	140	144	206	220	262	297
COUNTY GROUP 2	26	30	114	147	187	276	294	483
COUNTY GROUP 3	2	2	10	18	22	48	55	115
COUNTY GROUP 4	1	2	3	12	5	25	11	50
COUNTY GROUP 5	1	1	2	6	2	10	3	14
COUNTY GROUP 6	10	14	32	71	59	143	72	251
COUNTY GROUP 7	3	5	14	35	18	60	25	103
COUNTY GROUP 8	2	2	14	37	22	111	29	271
COUNTY GROUP 9	0	0	0	0	0	0	0	0
COUNTY GROUPS 1-4 Nonmetropolitan	78	83	267	321	420	569	622	945
COUNTY GROUPS 5-9 Metropolitan	16	22	62	149	101	324	129	639
ALL U.S. COUNTIES	94	105	329	470	521	893	751	1584

PRIMARY PATIENT CARE EXCL. I&R (GP,IM,PED,OBGYN)

COUNTY GROUP 1	48	48	153	156	226	239	285	320
COUNTY GROUP 2	33	36	148	189	241	351	377	615
COUNTY GROUP 3	0	0	17	24	47	80	108	214
COUNTY GROUP 4	1	2	4	14	12	40	29	100
COUNTY GROUP 5	1	1	2	6	3	12	4	17
COUNTY GROUP 6	8	13	34	76	64	159	84	306
COUNTY GROUP 7	4	6	14	39	21	71	30	128
COUNTY GROUP 8	2	2	14	45	27	150	40	364
COUNTY GROUP 9	0	0	0	0	0	0	0	0
COUNTY GROUPS 1-4	82	86	322	383	526	710	798	1249
COUNTY GROUPS 5-9	15	22	64	166	115	352	154	615
ALL U.S. COUNTIES	97	108	386	549	641	1102	956	2064

PRIMARY PATIENT CARE EXCL. I & R PLUS GENERAL SURGERY

COUNTY GROUP 1	44	44	136	139	201	213	256	286
COUNTY GROUP 2	23	26	104	139	174	261	275	448
COUNTY GROUP 3	0	0	7	13	18	36	49	98
COUNTY GROUP 4	1	2	3	11	5	23	9	45
COUNTY GROUP 5	1	1	2	6	2	10	3	16
COUNTY GROUP 6	7	11	28	66	51	133	72	240
COUNTY GROUP 7	3	6	12	35	16	61	22	59
COUNTY GROUP 8	2	2	13	36	20	89	29	221
COUNTY GROUP 9	0	0	0	0	0	0	0	0
COUNTY GROUPS 1-4	68	73	250	302	398	533	589	879
COUNTY GROUPS 5-9	13	20	55	143	89	293	126	576
ALL U.S. COUNTIES	81	93	305	445	487	826	715	1455

	Ratio 40		Ratio 45		Ratio 50		Ratio 55		Page
	Ratios per 100,000 population								
OFFICE-BASED PRIMARY CARE PLUS GEN.SURG.	# CO	# DR	# CO	# DR	# CO	# DR	# CO	# DR	
COUNTY GROUP 1	355	528	443	662	497	822	545	900	
COUNTY GROUP 2	515	1117	627	1594	706	2127	770	2155	
COUNTY GROUP 3	164	458	224	805	270	1224	325	1733	
COUNTY GROUP 4	48	231	83	461	108	803	146	1275	
COUNTY GROUP 5	8	43	15	86	27	175	37	323	
COUNTY GROUP 6	117	606	146	980	183	1592	215	2550	
COUNTY GROUP 7	51	285	63	477	76	754	88	1264	
COUNTY GROUP 8	64	919	84	1420	104	2210	112	3221	
COUNTY GROUP 9	0	0	1	12	3	80	4	184	
COUNTY GROUPS 1-4 Nonmetropol.	1126	2334	1377	3522	1581	4976	1790	6567	
COUNTY GROUPS 5-9 Metropolitan	240	1853	309	2575	393	4851	456	7526	
ALL U.S. COUNTIES	1366	4187	1686	6497	1974	5827	2246	14228	
PRIMARY PATIENT CARE EXCL. I & R (GP, IM, PED, OB, GYN)									
COUNTY GROUP 1	418	562	464	706	517	877	563	1044	
COUNTY GROUP 2	603	1384	714	1541	779	2524	825	3142	
COUNTY GROUP 3	240	758	306	1283	361	1867	397	2323	
COUNTY GROUP 4	53	516	123	915	160	1444	182	2000	
COUNTY GROUP 5	20	105	31	231	40	388	44	500	
COUNTY GROUP 6	159	957	197	1688	234	2766	283	4094	
COUNTY GROUP 7	64	426	80	807	95	1455	105	2257	
COUNTY GROUP 8	78	1158	100	1974	113	3004	125	4498	
COUNTY GROUP 9	1	16	2	33	6	114	7	305	
COUNTY GROUPS 1-4	1354	3260	1612	4850	1817	6712	1967	8775	
COUNTY GROUPS 5-9	322	2706	410	4733	488	7657	564	11784	
ALL U.S. COUNTIES	1676	5966	2022	9583	2305	14369	2511	20559	
PRIMARY PATIENT CARE EXCL. I & R PLUS GENERAL SURGERY									
COUNTY GROUP 1	383	511	434	649	491	809	540	929	
COUNTY GROUP 2	497	1078	601	1543	686	2075	756	2649	
COUNTY GROUP 3	145	425	200	726	261	1127	305	1631	
COUNTY GROUP 4	42	264	69	403	96	715	131	1137	
COUNTY GROUP 5	6	40	13	75	23	157	32	247	
COUNTY GROUP 6	112	573	140	899	170	1418	201	2235	
COUNTY GROUP 7	46	253	56	408	72	659	75	1078	
COUNTY GROUP 8	58	792	78	1280	95	1875	109	2751	
COUNTY GROUP 9	0	0	1	10	1	24	3	51	
COUNTY GROUPS 1-4	1067	2222	1304	3321	1534	4726	1736	6386	
COUNTY GROUPS 5-9	222	1658	288	2672	361	4133	424	6446	
ALL U.S. COUNTIES	1289	3880	1592	5993	1895	8859	2160	12832	

ACTIVE NON-FEDERAL M.C. RATIOS

NUMBER OF COUNTIES WITH LESS THAN SPECIFIED RATIO, AND NUMBER OF MD'S NEEDED TO BRING RATIO IN EACH COUNTY TO SPECIFIED RATIO, BY TYPE COUNTY, TYPE M.C., AND SPECIFIED RATIO

	Ratios per 100,000 population					
	Ratio 60		Ratio 65		Ratio 70	
	# CO	# DR	# CO	# DR	# CO	# DR
PRIMARY PATIENT CARE (GP, IM, PED, OBGYN)						
COUNTY GROUP 1	554	1225	619	1410	640	1598
COUNTY GROUP 2	860	3823	890	4548	900	5250
COUNTY GROUP 3	414	3220	430	3945	442	4753
COUNTY GROUP 4	156	2709	201	3424	208	4142
COUNTY GROUP 5	44	776	44	979	46	1179
COUNTY GROUP 6	268	4863	282	6421	291	8100
COUNTY GROUP 7	98	2022	105	2813	111	3718
COUNTY GROUP 8	113	4186	119	5466	130	7040
COUNTY GROUP 9	5	212	5	290	6	391
COUNTY GROUPS 1-4 Nonmetro.	2064	10577	2140	13327	2190	15783
COUNTY GROUPS 5-9 Metropolitan	524	12059	555	15949	584	20428
ALL U.S. COUNTIES	2592	23036	2695	29290	2774	36211
PRIMARY PATIENT CARE PLUS GENERAL SURGERY						
COUNTY GROUP 1	566	1128	600	1315	625	1497
COUNTY GROUP 2	805	3203	844	3874	868	4581
COUNTY GROUP 3	356	2152	388	2769	408	3465
COUNTY GROUP 4	156	1590	177	2189	188	2850
COUNTY GROUP 5	39	434	43	625	43	820
COUNTY GROUP 6	215	2784	236	3871	252	5101
COUNTY GROUP 7	79	1102	85	1496	93	1999
COUNTY GROUP 8	105	2882	107	3761	113	4702
COUNTY GROUP 9	4	77	5	135	5	213
COUNTY GROUPS 1-4	1883	8073	2009	10147	2089	12393
COUNTY GROUPS 5-9	442	7279	476	9888	506	12835
ALL U.S. COUNTIES	2325	15352	2485	20035	2595	25228
OFFICE-BASED PRIMARY CARE						
COUNTY GROUP 1	600	1249	623	1433	644	1625
COUNTY GROUP 2	872	3956	897	4687	907	5433
COUNTY GROUP 3	425	3455	438	4225	444	5040
COUNTY GROUP 4	202	2956	209	3732	215	4493
COUNTY GROUP 5	44	837	44	1038	47	1241
COUNTY GROUP 6	297	6438	305	8277	311	10177
COUNTY GROUP 7	119	3537	124	5243	125	6586
COUNTY GROUP 8	134	7503	141	9847	148	12465
COUNTY GROUP 9	11	1542	11	2258	13	3188
COUNTY GROUPS 1-4	2099	11656	2167	14077	2210	16591
COUNTY GROUPS 5-9	605	20257	625	26663	644	33657
ALL U.S. COUNTIES	2704	31913	2792	40740	2854	50248

OFFICE-BASED PRIMARY CARE PLUS GEN. SURG.	Ratio 60		Ratio 65		Ratio 70	
	# CO	#DR	#CO	#DR	#CO	#DR
COUNTY GROUP 1	574	1155	637	1344	631	1523
COUNTY GROUP 2	421	3349	656	4035	878	3750
COUNTY GROUP 3	371	2358	406	3007	423	3757
COUNTY GROUP 4	171	1862	186	2510	200	3207
COUNTY GROUP 5	40	459	43	696	44	644
COUNTY GROUP 6	252	3666	275	5164	290	6829
COUNTY GROUP 7	101	2012	110	2934	117	4061
COUNTY GROUP 8	121	4514	128	6278	134	8275
COUNTY GROUP 9	9	451	11	1026	11	1802
COUNTY GROUPS 1-4 Nonmetro.	1339	8728	2057	10956	2132	13242
COUNTY GROUPS 5-9 Metropolitan	523	1142	567	16159	590	21622
ALL U.S. COUNTIES	2462	19870	2624	27054	2728	35104

PRIMARY PATIENT CARE EXCL. I & R (GP, IM, PED, OB/GYN)

COUNTY GROUP 1	564	1227	619	1412	640	1600
COUNTY GROUP 2	860	3844	850	4569	902	5313
COUNTY GROUP 3	419	3272	432	4028	442	4818
COUNTY GROUP 4	200	2766	206	3455	210	4225
COUNTY GROUP 5	44	780	44	933	47	1185
COUNTY GROUP 6	289	5716	301	7500	306	6553
COUNTY GROUP 7	115	3258	123	4501	125	5837
COUNTY GROUP 8	130	6356	135	8523	144	10336
COUNTY GROUP 9	9	824	11	1451	12	2182
COUNTY GROUPS 1-4	2073	11109	2147	13504	2194	15976
COUNTY GROUPS 5-9	547	16574	615	22958	634	29493
ALL U.S. COUNTIES	2660	28033	2762	36462	2828	45469

PRIMARY PATIENT CARE EXCL. I & R PLUS GENERAL SURGERY

COUNTY GROUP 1	566	1135	600	1327	625	1517
COUNTY GROUP 2	907	3271	845	3941	869	4656
COUNTY GROUP 3	359	2228	392	2865	413	3593
COUNTY GROUP 4	141	1681	181	2306	195	2000
COUNTY GROUP 5	39	460	43	647	43	845
COUNTY GROUP 6	229	3272	257	4636	280	6202
COUNTY GROUP 7	91	1659	104	2693	110	3471
COUNTY GROUP 8	113	3866	123	5339	130	7171
COUNTY GROUP 9	6	177	7	334	9	950
COUNTY GROUPS 1-4	1693	8315	2018	10439	2102	12755
COUNTY GROUPS 5-9	478	9454	534	13459	572	18639
ALL U.S. COUNTIES	2371	17769	2552	23898	2674	31394

Table 2

DEMOGRAPHIC COUNTY CLASSIFICATION

Demographic County Classification	Definition	Number of SMSA's	Number of Counties	Resident Population (12-31-72)
Total 50 States and D.C.		295	3,084	209,448,200
9	Counties in SMSA's with 5,000,000 or More Inhabitants	3	15	24,033,800
8	Counties in SMSA's with 1,000,000 to 4,999,999 Inhabitants	32	160	62,728,300
7	Counties in SMSA's with 500,000 to 999,999 Inhabitants	39	130	27,691,000
6	Counties in SMSA's with 50,000 to 499,999 Inhabitants	178	319	38,944,000
5	Counties Considered Potential SMSA's	43	47	4,209,700
4	Non-Metropolitan Counties with 50,000 or more Inhabitants		222	16,057,300
3	Non-Metropolitan Counties with 25,000 to 49,999 Inhabitants		461	15,997,900
2	Non-Metropolitan Counties with 10,000 to 24,999 Inhabitants		930	15,133,600
1	Non-Metropolitan Counties with 0 to 9,999 Inhabitants		800	4,652,600

Note: Cities defined as independent are included in "number of counties" column.

Table 3

Measures of variation in selected State ratios of active non-Federal
M.D.'s per 100,000 population: 1973

Measure	Active non- Federal	Primary patient care		Primary patient care excluding interns and residents	
		GP, IM, Ped, Obgyn	GP, IM, Ped, Obgyn plus GS	GP, IM, Ped, Obgyn	GP, IM, Ped, Obgyn plus GS
U.S. average <u>1</u> /..	141.7	60.2	73.4	49.7	59.4
Highest State.....	218.2	87.2	107.0	66.2	77.7
Lowest State	72.6	37.4	47.6	36.5	44.1
Median of States.....	117.6	51.4	62.7	44.3	54.3
Ratio H/L	3.0	2.3	2.2	1.8	1.8
Ratio H/Median	1.9	1.7	1.7	1.5	1.4

1/ Weighted mean.

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Table 4a
Active non-Federal M.D.s, by county size and type of practice: 1973

County size, 1972	Number of counties	Population 1972	Active non-Federal M.D.'s				
			Total	Patient care	Primary patient care		
					Total	Excl. Int. & res.	Office-based
Total 1/	3,074	208,333,800	294,949	270,409	125,309	103,502	97,640
Less than 1,000	22	14,000	3	3	3	3	3
1,000 - 1,999	41	59,700	12	12	12	12	12
2,000 - 2,999	69	169,100	54	54	48	48	46
3,000 - 3,999	74	255,700	100	99	90	89	86
4,000 - 4,999	87	384,400	139	134	117	117	114
5,000 - 5,999	104	570,000	210	204	170	169	167
6,000 - 6,999	100	643,400	283	281	237	237	235
7,000 - 7,999	109	819,500	338	325	255	255	251
8,000 - 8,999	115	970,700	414	407	335	335	327
9,000 - 9,999	91	860,200	336	328	259	259	252
10,000 - 14,999	415	5,113,200	2,211	2,180	1,774	1,770	1,731
15,000 - 19,999	353	6,127,900	3,251	3,166	2,194	2,165	2,103
20,000 - 29,999	389	9,542,100	5,167	5,000	3,434	3,415	3,345
30,000 - 39,999	259	8,964,200	5,834	5,636	3,487	3,470	3,356
40,000 - 49,999	154	6,864,100	4,945	4,755	2,670	2,639	2,548
50,000 - 99,999	329	23,057,800	23,099	21,552	10,634	9,791	9,401
100,000 or more	363	143,917,800	248,553	226,273	99,590	78,728	73,663

1/ 50 States and the District of Columbia

Table 4b

Active non-Federal M.D.'s per 100,000 population, by county size
and type of practice: 1973

County size, 1972	Number of counties	Active non-Federal M.D.'s per 100,000 population			
		Total	Patient care	Primary patient care	
				Total	Excl. int. office-based and res.
Total 1/	3,074	141.6	129.8	60.1	49.7
Less than 1,000	22	21.4	21.4	21.4	21.4
1,000 - 1,999	41	20.1	20.1	20.1	20.1
2,000 - 2,999	69	31.9	31.9	28.4	28.4
3,000 - 3,999	74	39.1	38.7	35.2	34.8
4,000 - 4,999	87	36.2	34.9	30.4	29.7
5,000 - 5,999	104	36.8	35.8	29.8	29.3
6,000 - 6,999	100	44.0	43.7	36.8	36.5
7,000 - 7,999	109	41.2	39.7	31.1	30.6
8,000 - 8,999	115	42.6	41.9	34.5	33.7
9,000 - 9,999	91	39.1	38.1	30.1	29.3
10,000 - 14,999	415	43.2	42.6	34.7	33.9
15,000 - 19,999	353	53.0	51.7	35.8	35.3
20,000 - 29,999	389	54.1	52.4	36.0	35.1
30,000 - 39,999	259	65.1	62.9	38.9	38.7
40,000 - 49,999	154	72.0	69.5	38.9	37.1
50,000 - 99,999	329	100.2	93.5	46.1	42.5
100,000 or more	363	172.7	157.2	69.2	54.7

1/ 50 States and the District of Columbia

Table 5

ACTIVE NON-FEDERAL M.D. RATIOS

NUMBER OF COUNTIES WITH LESS THAN SPECIFIED RATIO, AND NUMBER OF MD'S NEEDED TO BRING RATIO IN EACH COUNTY TO SPECIFIED RATIO, BY TYPE COUNTY, TYPE M.D., AND SPECIFIED RATIO

D. TYPE A Active non-Federal	50 per 100,000			100 per 100,000			150 per 100,000			165 per 100,000		
	RATIO 1			RATIO 2			RATIO 3			RATIO 4		
	#_CO	#_DP	#_DB	#_CO	#_DB	#_DB	#_CO	#_DB	#_DB	#_CO	#_DB	#_DB
COUNTY GROUP 1	448	618		661	2584		676	4721		679	5366	
COUNTY GROUP 2	585	1558		882	8005		918	15371		920	17577	
COUNTY GROUP 3	154	530		381	5414		447	12728		450	15190	
COUNTY GROUP 4	21	134		157	3265		206	5589		211	12262	
COUNTY GROUP 5	4	32		31	665		46	2556		46	3175	
COUNTY GROUP 6	98	566		188	4019		267	15398		283	20117	
COUNTY GROUP 7	37	257		76	2111		104	7205		105	9644	
COUNTY GROUP 8	43	400		98	4436		116	13287		120	17121	
COUNTY GROUP 9	0	0		2	104		5	653		6	897	
COUNTY GROUPS 1-4	1208	2840		2081	19268		2247	42809		2260	50395	
COUNTY GROUPS 5-9	182	1255		395	11335		538	39099		560	50954	
U.S. COUNTIES	1390	4095		2476	30603		2785	81908		2820	101349	

NOTE: Physician data is as of 12/31/73.

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Dr. COOPER. It is an extremely important question, Senator, and we will respond in detail.

Senator KENNEDY. I would like to work with you on that.

Dr. COOPER. We would be pleased to work with you.

Senator KENNEDY. What is the total cost of your package, Doctor?

Dr. COOPER. As Dr. Altman said earlier at the present time we are trying to work out the details of implementing this program within the context of this present 1976 budget. We have not yet finalized our discussion within the administration about 1977, and I am not in a position to be responsive about that at this time.

Senator KENNEDY. When will you have that?

Dr. COOPER. The 1977 number will be available when the President finalizes the 1977 budget.

Senator KENNEDY. That is not until next year?

Dr. COOPER. That is in January.

Senator KENNEDY. You can give us something.

Dr. COOPER. We will be glad to explore the estimates of the package with you.

Senator KENNEDY. Why do we not stay at last years plus 20 percent?

[Laughter.]

Senator KENNEDY. I must say I think it has been enormously forthcoming of the administration to present this important statement.

We have not had a chance, as you know, to peruse it, having received it just a few moments ago.

Dr. COOPER. Yes. I apologize.

Senator KENNEDY. So, at the risk of making hasty comments about it, let me say I am indeed impressed by what has been said. By the most imaginative position which you have taken on this enormously complex and difficult issue. Which I think is the basis of not only a manpower policy, but also deals with a significant part of our problem concerning quality care.

I think the administration, this team, obviously has done a lot of work in developing it and deserves a great deal of credit.

There are times when we go back and forth on questions, but I think this statement today is enormously forthcoming. And I think it can be the basis for some terribly important legislation which will be very meaningful for the American people.

I would like to ask you whether you have intentions to draft this proposal and, if so, how quickly?

Dr. COOPER. We are as concerned with time as you are, Senator, and we appreciate the kind comments.

We are beginning drafting legislation this morning, now that we have finalized the position. We hope to get this drafted and cleared through the process within 2 weeks.

Senator KENNEDY. I would like to see if we could initiate some communication between our staffs. I think we can make important progress on this if we can do that.

Dr. COOPER. We shall do all we can to expedite it.

Senator KENNEDY. I hope all the staff will participate.

Senator BEALL. I would like to join with Senator Kennedy in congratulating you, Doctor, and the staff for coming here so well prepared with this proposal for our consideration, and I am happy that if there is a resemblance to what the Senate passed last year.

I think that as a result of your testimony here today, and as a result of the cooperation of the staff, we can get some legislation out expeditiously.

It seems to me that the famous light at the end of the tunnel is now very bright.

Senator KENNEDY. That is always dangerous to say. This might prove the exception.

Dr. COOPER. In this matter, the administration did debate on all the specific issues and tried to draw from the strong points of all proposals that we had previously dealt with.

Although it has been a long effort, we think it is a rewarding experience.

Senator KENNEDY. I think so, too.

Was it an easy one?

Dr. COOPER. No. We had vigorous positions from all quarters to consider, but I think we did arrive at maybe not a consensus but a strong effort at solving the problem.

Senator KENNEDY. That is certainly my impression, too. I think that is obviously Senator Beall's and also would be that of the other members of the committee.

We are extremely grateful.

[The prepared statement of Dr. Cooper, follows:]



FOR RELEASE ONLY UPON DELIVERY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

BY

THEODORE COOPER, M.D.

ASSISTANT SECRETARY FOR HEALTH

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON LABOR AND PUBLIC WELFARE

UNITED STATES SENATE

TUESDAY, SEPTEMBER 16, 1975

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE

It is a pleasure to have this opportunity to share our views regarding the problems of health manpower in the Nation today and the many bills which are before you today, including S. 989, the "Health Professions Educational Assistance Act of 1975;" S. 1357, the "Health Manpower and Shortage Area Assistance Act of 1975;" S. 922, the "Health Manpower Act of 1975;" S. 991, the "National Health Services Manpower Act of 1975;" H.R. 5546, the "Health Manpower Act of 1975;" and the Administration's new proposal for health professions educational assistance and our pending proposal, S. 1753, the "National Health Service Corps Amendments of 1975."

As we pointed out during our appearance last summer when similar legislation was considered, although we did not fully agree with some of the provisions in bills similar to those before you today, the approach taken by these bills conforms in a number of areas to the Administration's position. This is even more true today for in the past year the Administration has reconsidered its proposal and developed what we feel is a more effective approach to addressing the complex health manpower issues confronting the nation.

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Before presenting our specific proposal, I think it would be useful to summarize briefly what we continue to feel are the major issues which surround new health manpower legislation.

Changes in the Training of Health Manpower

As we pointed out in earlier testimony before this Subcommittee, health manpower training programs have experienced significant changes over the past ten years. First, there has been a substantial increase in the national capacity to train health professionals. Since 1963, Federal programs have assisted in the building of 21 medical schools, nine dental schools, one school of osteopathy, and one school of veterinary medicine. About 1,600 medical and 650 dental school student positions have been substantially assisted as a result of Federal construction programs.

Second, enrollment has increased significantly for schools of medicine, dentistry, and nursing. First-year medical school places grew from 8,759 in 1965 to 14,937 in 1974. It is impossible to measure the exact impact of Federal programs in this increase; but we believe that our efforts have had a significant effect. Where first-year enrollment rose at an annual rate of 1.3 percent between 1950 and 1965, the annual growth since 1965 has been almost 7 percent.

Third, minority enrollment has risen substantially in medical and dental schools. First-year enrollment of black students in U.S. medical schools has increased from 4.2 percent in academic year 1969-1970 to 7.2 percent in academic year 1973-1974. There has also been a corresponding increase in the first-year enrollment of women in medical schools from 9.2 percent in 1969 to 19.6 percent in 1973-1974.

At the same time, however, schools have begun to desire considerable fiscal resources from the Federal Government. Over the past ten years, annual Federal obligations for health manpower programs, not including research training or mental health manpower, have grown from \$65 million in 1963 to \$681 million in 1974. Between 1963 and 1974, a total of approximately \$4 billion was obligated for the training of health professionals. Federal funds from all sources now account for nearly 50 percent of the revenue to U.S. medical schools, making the Federal Government the largest single supporter of medical schools. And even with this large investment of Federal dollars, health professions education programs have had only very limited success in addressing issues beyond that of increasing numbers of health professionals.

Existing Problems

We believe there are four persistent deficiencies of the health care system related to achieving equity in access to quality health services at a reasonable cost for all persons.

1. Overall shortage and uneven geographical distribution of primary care services.
2. Distortions (apparent oversupply or undersupply) in the national supply of secondary and tertiary (specialty) care services, including uneven geographical distribution.
3. Continually rising costs and uneven productivity in services delivery, particularly as associated with delivery system organization.
4. Lack of uniform standards for assuring adequate levels of quality in service delivery.

When we evaluate alternative ways to resolve these deficiencies, it becomes increasingly clear that the solutions to many of today's major issues will not be simple and certainly cannot be resolved through passage of any one manpower bill. Health manpower problems cannot be attributed to any single cause but, in our view, are structural conditions of our complex, pluralistic, largely-private national health care system.

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It is unlikely that any single approach will resolve these complex issues. The ability of the Federal Government to solve all of these problems is limited. The legislation that should be enacted should reflect these limitations in seeking to improve distribution of the Nation's health professions.

Mr. Chairman, health manpower production systems must modify both their processes and outputs to effectively contribute to the long-range attack on the four persistent service delivery problems. We believe that the critical issues which must be addressed involve:

- Adequacy of Supply
- Foreign Medical Graduate (FMG) Quality
- Geographic and Speciality Distribution
- Productivity
- Equity

Adequacy of Supply

With respect to the supply of health professionals, we find that, in general, the allied health and nursing professions adjust reasonably well to market demands without substantial Federal assistance. The shortness and relatively low cost of these training programs, together with localized demand, contribute to this response. Both public and private training institutions have responded quickly as the demand for nurses and allied health personnel grew.

With respect to the medical and dental professions, we have developed a series of manpower supply and requirement projections. These projections indicate that if we maintain our present and planned output capacity, we can expect by 1985 to have increased the number of physicians by more than 50 percent and dentists by 40 percent. While about 9,000 graduated from medical school in 1971, the expected number of graduates in 1977 will be in excess of 13,000. The pipeline to train physicians is now in place and we are just beginning to feel its impact. Thus, in terms of absolute numbers, the U.S. physician pool is expected to be between 495,000 and 520,000 and the U.S. dental pool between 135,000 and 145,000 by 1985, up from 323,000 and 102,220, respectively in 1970. With respect to nursing, we estimate this pool to range between 1,000,000 to 1,100,000 individuals in 1980, up from the 720,000 in 1970.

Projected increases in physician supply are even more significant when viewed in connection with the expected population growth. Assuming a population growth rate of slightly greater than one percent, the physician population ratio will increase substantially from 158 per 100,000 in 1970 to between 207 and 217 in 1985. These rates would place the U.S. near the top of all the industrialized nations in terms of overall physician supply.

We have also considered how changes in insurance coverage and provider productivity may affect manpower requirements. Using what we consider to be a reasonable range of estimates for demand and productivity increases, we estimate that by 1980, physician requirements will be between 400,000 and 450,000. This compares to a supply projection of between 435,000 and 450,000 for 1980. This supply projection assumed that the 1975 medical school capacity would be maintained. If the annual rate of enrollment increases of the past five years of over 6 percent were to continue, however, we would increase the likelihood of an excess of above the estimated number of health professionals needed.

A surplus of health professionals may at first seem attractive but upon more careful examination several undesirable consequences emerge. Because physicians tend to have considerable control over the volume and mix of services they deliver, and the pricing of these services, a surplus of physicians is likely to yield:

- an increase rather than decrease in the total and perhaps even per unit cost of health services (each graduate is expected to generate \$100,000-\$200,000 per year in fees and services);
- a reduction in productivity, which may affect the quality of care rendered;

- a displacement of other types of health manpower from their roles in the health delivery system--e.g. the physician extender.

These supply and requirement projections raise the question of whether the Federal Government should continue to follow policies which would encourage continued expansion in the output capacity of U.S. health professional schools.

Foreign Medical Graduate Quality

These supply projections for physicians which I have just discussed take into account the future inflow of foreign trained physicians, a subject of significant concern to this Subcommittee. Increases in the numbers of U.S. graduates and the likely actions of both the private and public sectors in addressing the training of graduate physicians, both foreign and domestic educated, may well produce a downward trend in the influx of foreign medical graduates. Our estimates take into account a possible reduction by as much as 40 percent of the FY 1972 level.

Since the mid-1960's FMGs have been entering this country at approximately the same level as U.S. medical school graduates. The increase in the inflow of FMGs resulted from the change in the immigration laws which permitted much higher levels of immigration from the Eastern hemisphere, particularly Asia. The increased numbers of foreign-trained physicians has resulted in concern expressed in a number of quarters that feel the high utilization of FMGs in this country is undesirable. Some are morally concerned with the "brain drain" from underdeveloped countries, some with the fact that U.S. citizens are being denied a medical education that others with a belief that patient care provided by FMGs is of poorer quality.

I feel that we should not restrict qualified foreign physicians from immigrating to this country. A fundamental strength of this country has been that it has permitted individuals to enter freely. Through such policy both the individual and this country have benefited greatly. I am equally strong in my belief that those foreign physicians who are allowed to practice here meet the same rigorous standards that we have for U.S. graduates. Although there is no definitive work indicating that FMGs are of an inferior quality, the quality issue is of major concern to the Department.

Geographic and Specialty Distribution

In the past, Federal policies toward specialty and geographic distribution of health professionals have relied too heavily on a notion that an increase in total supply would solve the distributional problems. If large enough numbers of health professionals are produced, it was reasoned, competitive pressure would force them to practice in non-metropolitan areas and in the medical specialties that offer lower income potentials, longer working hours, and/or relatively lower levels of prestige. Experience has shown this reasoning to be incorrect.

During the 1960's and 1970's, while there was a significant increase in the supply of physicians, the absolute number of primary care physicians decreased sharply. There are, for example, strong indications to suggest that we are training too many of certain specialists. A number of professional specialty associations are increasingly concerned about the likelihood of oversupply in their specialties. As a result of this oversupply of certain specialists, primary care is often delivered by high-priced specialists in expensive settings and, in addition, it may be of lower quality.

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On the geographic side, while we have experienced a significant increase in our physician-population ratio during the 1960's and early 1970's, disparities in the distribution of physicians by States has actually worsened. Population groups in rural areas and in the inner city have had difficulty gaining access to health care.

Policies aimed at solving the problem of geographic and specialty maldistribution which concentrate on increasing the aggregate supply of health manpower probably will continue to be extremely expensive and largely ineffective.

Productivity

Sheer numbers do not seem to be the answer. Increased physician and dentist productivity, on the other hand, may have the potential to contain the cost of medical services. Even more important, increased productivity may lower the levels of health professionals required. If, for example, annual physician productivity, as measured by physician visits, were to increase by one percent annually for ten years, over 30,000 fewer physicians would be needed to provide the same total number of visits. This is a goal clearly within our grasp. It is now well documented that many tasks performed by physicians and dentists can be performed by health personnel who require a shorter period of training. Yet, there is evidence that physicians and dentists are employing and utilizing effectively too few assistants

and that by increasing the number of assistants they use, they could greatly increase their output.

In addition, physician assistants, nurse practitioners, and expanded dental auxiliaries offer even greater potential for productivity increases than traditional aides. Dentists practicing with teams of four specialty trained auxiliaries have been known to increase their productivity by 130 percent over that of the dentists working with only one chair-side assistant. Other studies have shown that a physician assistant can increase a physician's productivity by between 30 and 70 percent.

Therefore, it is in the interest of the Federal Government to continue to address the issue of appropriate task delegation and non-physician training programs.

Therefore, it is in the interest of the Federal Government to continue to address through demonstrations of innovative solutions the issue of appropriate task delegation and non-physician training programs.

Equity

As a generalization, schools of the health professions are tending to look increasingly for Federal support as a primary source of income for many programs and have sought non-Federal support to meet financing requirements unmet by the Federal Government.

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From 1959 to 1970, Federal support increased from 29.5 percent of the total income for medical schools to almost 50 percent. At the same time, State appropriations remained constant at 15 percent and tuition income decreased from 7.6 percent to 3.7 percent. It should be noted, however, that these figures relate to income from all sources - that is they include funding from all Federal agencies for biomedical research and patient care (Medicare and Medicaid).

Students of health professional schools have not been asked to assume a proportionate share of their increased educational costs. A review of the distribution of tuition charges by schools shows that 80 percent of the publicly supported institutions plan next year to charge resident students \$1,200 or less, with 70 percent of the private schools expected to charge \$3,000 or less. In view of the high earnings of health professionals, particularly physicians and dentists, and the relatively low educational costs they bear, the rate of return on a basic medical and dental education has been estimated to be two to three times that of graduate education generally. Stated another way, the full personal investment in a medical education can be recouped on the average with five years of practice. Moreover, interest in these career fields is increasing. An example of the attraction of these professions is the ratio of the applicants to places--currently approximately 3 to 1--and increasing steadily. Also, an examination of the stated career plans of today's undergraduate student

population reveals that enthusiasm for a health professions education and career is rising dramatically. Moreover, the health professions have experienced Federal financial support in major ways not generally available to other fields of education and training.

Federal Role

The objective of the Federal Government in health manpower production is to assure that the Nation's health care system has an adequate supply and an appropriate mix and distribution of qualified personnel for the system to effectively and efficiently achieve national health care goals. At the present time, the major means of fulfilling this objective have been direct Federal capitation grants to training institutions and direct assistance to students. We have weighed the efficacy of these two particular types of support in light of the persistent national health manpower problems. The question simply put is "How can Federal funds be most effectively channeled to accomplish existing national objectives?" In the past year this question has become even more critical because of the Nation's serious economic difficulties.

While it is true that capitation support has been successful in encouraging schools to expand their enrollment, in our view, capitation grants have not been effective in achieving

changes that are necessary to address the manpower distribution problems facing us. In 1971 when the present legislation was drafted, one of the major issues which that legislation addressed was the serious geographic and specialty maldistribution of health professionals, especially physicians. In the past four years, however, even with substantial institutional support the geographic maldistribution is becoming worse rather than better. Specialty imbalances continue to exist. What is required is a redirection of Federal support.

Also, health professional students can and should be called upon to assume an increasing share of their educational costs. We are not asking students to pay for their entire educational costs. Capitation grants, which it should be noted amounted to about \$2,000 in 1974 for schools of medicine, did not cover the entire costs either. Current tuitions covering only 10 or 20 percent of such costs are, in our view, too low. Furthermore, the need and purpose of student assistance also have changed over the past decade. Ten years ago health educators believed that scholarships and subsidized loans were necessary to assure enough qualified applicants. Today there is a surplus of qualified applicants. The high personal satisfaction and the anticipated financial rewards in all health professions are more than sufficient to attract adequate numbers of qualified applicants.

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The Administration Proposal

As noted earlier, we feel that the changing nature of our health manpower problems necessitates a significant change in Federal policy direction and spending patterns. Federal dollars should be directed into new programs which promise to be effective in resolving the persistent manpower problems facing us and withdrawn from those that do not. Being cognizant that institutions, particularly complex ones like health science centers, need time to adjust, we will be phasing down or out most old programs as we move into new areas.

For those manpower categories requiring no more than a baccalaureate degree, generally: educational opportunities are more evenly distributed nationally; most of the fiscal resources for institutional operations flow from state, local government, and private sources; more students are originally residents of the states in which the institutions are located; graduates are generally less mobile; output capacity is more readily adjustable to state and local needs, without significant impact on national supply; available Federal assistance through the Office of Education provides a larger portion of student training expenses.

However, the obverse of these general propositions holds for certain manpower categories requiring postbaccalaureate

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training. The output of schools of medicine, osteopathy, and dentistry, thus, determines nationwide supply in these manpower categories. Adjustments in output capacity by these institutions to meet national needs placed inequitable burdens on the resources of state and local jurisdictions and the private organizations on which the schools partially depend for operational financing. More importantly, medical, osteopathic and dental schools are multi-purpose institutions performing other national functions: they conduct the bulk of Federally financed biomedical research and development; they deliver a substantial amount of the Nation's hospital based patient care, of which 27% is Federally financed. Significant fluctuations in the support of separate but interrelated activities of these institutions affect all outputs in the learning-teaching-service-research process.

On the basis of these considerations, some Federal health manpower institutional support is both necessary and desirable for assuring change in medical and dental schools, but does not appear necessary or justified for other health professional schools.

Federal student assistance and discretionary support are needed for selected training, and justified for facilitating and reinforcing the needed changes in all postsecondary manpower production systems. Such programs are required

to stimulate: output of specific manpower types determined to be in short supply nationally; development of new and revised health roles to increase efficient utilization of manpower and manpower productivity; research and development to improve the educational training process.

Capitation

Capitation support should continue for schools of medicine, osteopathy, and dentistry, but only to those schools that agree to meet critical national objectives for schools choosing not to participate in a conditional capitation program, capitation would be phased-out over three years. Given the crucial importance of these schools in determining the type, distribution and quality of health care personnel, a stable and continuing Federal medical school partnership is desirable. We view capitation support which contains no conditions as unnecessary subsidy to students. However, once meaningful national priority conditions are attached to capitation such funds can no longer be viewed as simply a student subsidy. Medical, osteopathic and dental schools will be asked to help solve the geographic and primary care problems in exchange for capitation support. In establishing these special capitation conditions, we selected those factors the schools have control over and those factors that can be measured for compliance.

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We propose that for those schools participating in the new incentive capitation levels be established at \$1,500 per year for each medical, osteopathic, and dental student. Capitation would be terminated for pharmacy and phased-out over the next three years for veterinary medicine, optometry, and podiatry.

To help correct geographic maldistribution, each medical and dental school will be asked to set aside an annually increasing percentage of their first year places for qualified students who voluntarily agree to practice in an underserved area. Such a requirement would commence at 15 percent in FY 77, increasing to 25 percent in FY 79. The special admissions criteria would be linked to capitation support in order to:

- o yield a system-wide response to a critical health manpower problem and the need for a physician draft
- o assure that not only the lowest-income students provide public service
- o make schools more aware in the admissions process of the national importance of accepting and training individuals willing to fill health service voids.
- o provide in each school a large enough pool of committed students so that the curriculum changes necessary for preparing students for service in rural and inner-city areas would occur.

Other proposed conditions attached to capitation would be linked to increased primary care training. All medical schools will be asked to establish an administrative training unit in family practice or primary care, and to have a high proportion, eventually 50 percent, of their filled affiliated residencies in primary care. These conditions were included in recognition of the importance of medical school environment on specialty choice.

Residency training provides the bulk of clinical experience and determines the specialty of physicians. Therefore, medical school responsibility does not conclude with the awarding of a medical degree, but throughout residency training. Roughly 90 percent of all residencies are affiliated with medical schools. It is claimed that the individual decisions of thousands of teaching physicians to establish residency programs do not produce a proper distribution of residencies. As there are only about one hundred medical schools and they represent the aggregate decisions of the teaching physicians, they represent a reasonable locus to place the responsibility for better distribution of residencies. By requiring medical schools to have a high percentage of their filled affiliated residencies in primary care, we will be able

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to bring about a proper balance between the number of primary care/non-primary residencies without restructuring all graduate medical education or by Federally regulating the size, composition, and geographic distribution of residency programs.

Student Assistance: Loans

Last year the Administration proposed, in H.R. 13059, an expanded guaranteed student loan program for graduate level training. We recommended that the total existing loan ceiling also be increased from \$2,500 to \$7,000. We again recommend that these ceilings be increased. Most students should have little difficulty in paying back these higher loans.

Consolidated Scholarship Program

Geographic maldistribution of health manpower represents one of the greater barriers to access to quality health care. Despite increases in the total number of health manpower personnel, geographic maldistribution has increased in the last ten years. Without direct intervention, this condition, primarily affecting rural and inner city areas is not generally expected to improve.

Existing scholarship programs (Public Health and NHSC Scholarships and Physician Shortage Area Scholarships) can continue to address these problems; however, since these separate programs were established at different times and for discrete purposes, existing authorities tend to overlap and policies often appear to conflict. Much more could be accomplished through a single broad and conditional health manpower scholarship program.

The broadened program would serve as a mechanism for addressing geographic distribution, fulfilling various HEW internal health manpower requirements, and offer potential, at least, for addressing problems associated with the maldistribution of medical specialties.

A conditional scholarship program would also be consistent with the principle that the public is ordinarily entitled to public service, or service meeting a public need, from those individuals who receive special scholarship assistance while preparing for a health professions degree.

We propose to consolidate the existing programs for Public Health and NHSC Scholarships and Physician Shortage Area Scholarships into one broadened conditional scholarship

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program. Under the program participants could be assigned to a Federal health service or other areas of critical need. Certain participants could serve in the National Health Service Corps, while others could serve in other parts of DHEW. Still others could serve elsewhere in other Federal agencies, or State or local government. All participants would have to be involved directly in the delivery of health care services, although the broadened authority would permit a service obligation to be fulfilled by individuals practicing their skills as private practitioners.

The proposal would continue the broad existing statutory authority for providing conditional scholarship assistance to all health professions, nurses, allied health professions, and other related health personnel. The service commitment would consist of one year service for each year of assistance; however, a minimum of two years would be required.

A payback provision in lieu of service would be available. Payback would be equal to twice the cost of support (minus any time equivalent already fulfilled), plus compound interest at prevailing market rates dating back to the first year recipients received scholarship support.

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Payback or services would begin immediately after the completion of training -- in the case of medicine, deferments would be granted for the period of residency training. Payback, in lieu of service, would be made in equal annual installments with the number of installments equal to the number of fiscal years for which the student received such scholarship support. Payback could be waived by the Secretary in the case of death of the recipient or in other cases where payback would be against equity and good conscience.

Unlike some proceeding scholarship programs, a direct Federal relationship would be established between DHEW and the student.

Pre-Admission and Scholarship Assistance for the Disadvantaged

There has been significant under-representation of students in health professions schools from among individuals who, due to socio-economic factors, are financially or otherwise disadvantaged. This has been a major factor in the resulting under-representation of racial minorities among practitioners of the health professions.

In recent years significant progress has been made. As noted earlier, the percentage of minority students in the first-year classes of medical schools has risen steadily.

These students are largely from families of low income, 20 percent are from families with less than \$5,000 per year income and 67 percent from families of less than \$10,000 per year. Regardless of the gains made through improved educational opportunities in the preparation of such students for entry into health profession schools, these students remain the most vulnerable in terms of educational and economic risks.

We propose that a special pre-admissions and scholarship program be established for the disadvantaged enrolled in post-baccalaureate programs. It would provide up to two years of stipends for students in pre-admission programs, and scholarships for students from disadvantaged backgrounds for their entry year in a MOD school. The scholarship is limited to the entry year because upon successful completion of the first year in school, students gain confidence and therefore become more willing to take out loans.

Special Projects

One of the most effective means for carrying out specific Federal initiatives is through targeted special projects grants and contracts. In this way, support can be directed to specific objectives carrying the highest Federal priorities, and efforts can be more effectively traced and evaluated.

We feel that discretionary funds should only be used to stimulate action to achieve national goals not likely to be addressed adequately from other sources. Discretionary funds should not become basic institutional support but should provide a short range stimulus to desired action by institutions. Projects supported under these discretionary authorities should be used for the purpose of initiating or demonstrating new activities or modifying or augmenting existing ones for a limited period of time and not for long-term operational support. The agreements under which such activities are supported with Federal grants or contracts should contain a plan for phasing out this type of support and for either ending the activities or supporting them from non-Federal sources. In most cases, project periods should be no longer than three years, but in no case would projects be eligible for more than five years of support without the specific approval of the Secretary.

We propose that these special activities be included under a single new authority, the provisions of which would focus on the major manpower problems facing us.

A. Family Medicine Residencies and Training

We would authorize grants to schools of medicine and osteopathy to establish or significantly expand family medicine residency programs and other training in family medicine. Priority would be given to applicants proposing that a substantial portion of training experience shall take place in a primary care setting at a site geographically remote from the training institution or in an inner city or rural area deficient in health services resources. Funds could be used for trainee stipends, undergraduate training, faculty training (especially of local practitioners), honoraria for preceptors, and travel and living expenses in remote sites, among other purposes.

B. Primary Care Residencies and Training

Grants would be authorized to schools of medicine, osteopathy, and dentistry to establish or significantly expand affiliated residencies, clinical clerkships, or supervised externships in the primary care specialties of general internal medicine, general pediatrics, geriatrics, and general dentistry, under the same priority provisions as the grants for family medicine training.

C. Grants to VOPP Schools

There should be authority for grants to schools of optometry, pharmacy, and podiatry to develop affiliations with medical schools, establish clinical training relationships with nursing homes and home health agencies, develop curriculum focusing on needs of the elderly, provide training in clinical pharmacology, and train pharmacists to counsel patients on drug effects. Schools of veterinary medicine would be encouraged to develop programs contributing to the improvement of human health. These schools and also schools of veterinary medicine should be eligible for grants to place graduates in underserved areas.

D. Training of Public Health Professionals

We would authorize grants for graduate training in epidemiology, biostatistics, population studies, health education, environmental and industrial health, public health nutrition, and health service systems planning and management. Priority would be given to applicants planning outreach activities to a sizeable geographic region.

E. Grants to Schools Training Allied Health Professionals

In the field of allied health professions training, there should be grants to schools or contracts with public or nonprofit private institutions to support program improvement, curriculum development, advanced training and the development of standards of competence of professional personnel. Priority would go to applicants training personnel crucial to the support of primary care practitioners or in specialties having critical manpower shortages.

F. Training of Physician and Dentist Extenders

We would authorize grants to schools of medicine, dentistry, or consortia of schools of medicine and nursing to train primary care physician extenders; and grants to dental schools for the training of expanded function dental auxiliaries. Training would be required to take place in conjunction with the training of undergraduate and graduate students utilizing a curriculum designed to identify and promote efficient sharing of responsibilities. Priority would be given to projects providing training in locations removed from the schools or in areas with a shortage of health service resources; and to applicants operating as an integral part of the program an effort to place graduates in resource short areas.

G. Grants to Ameliorate the Effect of Geographic Maldistribution

To ameliorate the effect of geographic maldistribution, we would make grants for Community-Based Health Manpower Education Programs, Medical School-Based Area Health Education Centers, and Communications Technology projects establishing data transmission and backup consultation linkages between medical

schools and remotely-based rural physicians. Support would be provided for community-based training of students, regional systems of continuing education, and rotation of faculty and programs to upgrade the teaching skills of local professionals.

H. Assistance to Foreign Medical Graduates

We would authorize grants to schools of medicine and osteopathy for programs to assist U. S. students now enrolled in foreign medical schools in qualifying for transfer to U. S. medical schools with advanced standing. To upgrade the skills of foreign medical graduates already in this country, we would make grants to hospitals to provide FMG residents with intensive clinical instruction (through contracts with medical schools) and intensive English language instruction.

Innovation, Development and Demonstration Grants

In addition to supporting activities which we know will be effective in resolving the distributional problems facing us, we need to develop new and improved approaches to the education of health professionals.

Such investments are necessary if we are to develop long-range solutions to the difficult manpower issues confronting us today. We need to develop, demonstrate and evaluate new or substantially improve existing approaches to health manpower education and training. Examples of such activities would include the development of regional training facilities, the "schools without walls" concept, methods for lowering costs of training, evaluating changes in admission criteria to select individuals more likely to practice in medically underserved areas, innovative curricula, and various forms of interdisciplinary training.

Primary Care Training Facilities Construction

As a further specifically targeted effort, we propose to support construction of needed primary care training facilities through a revision of the newly enacted health facilities project grant program in Title XVI, PHS Act.

Grant authority would be used to support the construction or modernization (renovation or replacement) of facilities to provide instructional space for primary care training and related activities. This would include ambulatory patient care and community-based training sites. These project grants would be targeted to those institutions offering greatest potential for increasing educational opportunities for future primary care practitioners.

Further Federal assistance in this area would be in the form of loan guarantees for renovation, remodeling, or new construction of teaching facilities of schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, and podiatry. This approach would help assure maintenance of the current output of existing institutions.

Financial Distress

Financial distress grants similar to those authorized under existing legislation should be available to health professions schools. Priority should be given to schools receiving capitation under the proposed law. In any given year, a school could receive no more than 75 percent of the amount received in the preceding year.

Graduate Medical Education Commission

Traditionally, the Federal role in specialty distribution has been limited to special project grants and other types of similar activity, discretionary on the part of the Federal government, and voluntary with respect to the participation by graduate medical programs. Given the growing problem of specialty maldistribution, however, it is unlikely that any combination of Federal special project grants can adequately cope with the problem. The problem is clearly manifested by the reduced number of physicians entering primary care specialties, while the absolute number of physicians is increasing. For example, 47.9 percent of all active non-Federal physicians were in primary care specialties in 1963 as opposed

to 44.9 percent in 1972. The difference is far greater if the number of internists who enter subspecialties are excluded from this total. For the same period, the number of general practitioners dropped from 25.6 percent to 15.8 percent. Further, of the 51,115 residency positions offered in September 1972, only 17,934 were in primary care, of which 2,089 went unfilled.

Conversely, while there is an insufficient number of primary care physicians, there appears to be a surplus of the number of physicians in other specialties. Unfortunately, while opinions differ regarding what constitutes a sufficient number within each specialty, there is general agreement that certain specialties are in excess of national needs.

As the Subcommittee is well aware, there are several reasons for the anti-primary care bias in existing residency programs. One reason is that institutions have great incentives for establishing large numbers of residency programs because they constitute a source of inexpensive physician manpower. In this way, training needs become secondary to an institution's service needs. Also, primary care has not attained

the prestige of other more established specialties. Primary care residencies also suffer because of current reimbursement policy. Because of third-party reimbursement policies, outpatient services usually operate at a loss.

We intend to establish administratively a National Commission on Graduate Medical Education Residency Programs (NCGME).

Foreign Medical Graduates

Addressing the problems associated with Foreign Medical Graduates necessarily includes the ethical issue in respect to non-U.S. citizens trained in foreign medical schools, practicing in the United States, and, as a consequence, being lost to their native country. There is, however, the more immediate and consuming problem, the question of FMG-U.S. medical school graduate skill comparability. This same question relates to American graduates of foreign medical schools.

At the present time, there are more than 63,000 graduates of foreign medical schools in the United States constituting more than 22 percent of the active physicians in this country. In some specialties, they constitute a third or more of the active positions, i.e., Pathology, Anesthesiology, Pediatric Cardiology, and Physical Medicine.

While some FMGs enter the United States as direct immigrants, a majority enter as post-graduate physician trainees under the exchange study of J-visa program. This program, conceived after World War II as a way to provide future leaders of foreign countries with experience in the U.S., has become a primary source of inexpensive medical manpower for many U.S.

health facilities. In 1972, more than 17,000 graduates of foreign medical schools were in post-graduate physician training programs in the United States, constituting over one-third of all of the trainees at the time. The 1972 amendments to the Immigration and Nationality Act has made conversion from the J-visa program to the immigration visa (i.e., a permanent resident status) a relatively simple task. It is our intention to work with the Department of State and other relevant Federal agencies on this issue.

As policy, DHEW currently supports the development of a single qualifying examination for all physicians who are entering hospital training programs where they will have some responsibility for patient care. We propose to convene appropriate organizations and groups for the development of such an examination. The existence of such an examination would introduce into the physician training experience a way to determine, for U.S. and foreign graduates alike, suitability for the years of graduate education. Because this examination is not yet established and because immigrant physicians should

be expected to meet standards of U.S. medical graduates in provision of care in the United States, it is proposed that the Department will determine the most appropriate screening examination for FMG's.

We propose to work with the appropriate professional organizations and the Justice Department in having this examination accepted.

In order to facilitate the return of U.S. citizens presently studying medicine abroad, efforts to accommodate transfer students into the U.S. medical education system must be expanded. This proposal would authorize financial assistance under the Special Project Authority to schools of medicine and osteopathy for the development of "transfer" training for qualified U.S. citizens enrolled in foreign medical schools at the time of the legislation, and who apply for advanced standing transfer to U.S. schools. These programs

would identify any academic deficiencies these transfer students may have and incorporate these transferers into the regular program of the school by providing any supplemental instruction necessary.

Since it is known that many foreign medical graduates are practicing in the United States in State hospitals on temporary, partial, or institutional licenses, programs would be established under the Special Project Authority to prepare these physicians for unrestricted licensure. This proposed effort would provide assistance to schools of medicine and osteopathy to develop preparatory courses directed at a well-defined population of nonfully licensed FMGs presently serving in State institutions. The course would prepare those FMGs to pass the appropriate State licensure examination, qualifying them for unrestricted practice within the State.

Manpower Analysis

The development of national health manpower goals and formulation of appropriate and effective health manpower strategies require sound analysis of information and data on the functioning of our health care system and the deployment and utilization of personnel within the system. At present

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the Federal capacity for such analysis is fragmented and inadequate. A centralized organizational capacity is required to assemble and aggregate information and data on the total health system from a national perspective.

We propose to establish a national health manpower analysis capability which includes data on all health professions personnel, including nursing, allied health, and health administrators. The Department would be authorized to enter into contracts with public and other nonprofit entities and contracts with other groups to improve the assembly, processing, and analysis of health manpower data and other relevant health system data. The authority would be used for national level policy and strategy analysis and would be used in close collaboration with the National Center for Health Statistics and with data collection and analysis efforts authorized under the recently enacted National Health Planning and Resources Development Act.

Comparison of Pending Bills

Mr. Chairman, I would now like to comment on four of the other bills before your Subcommittee today: S. 989, "The Health Professions Educational Assistance Act of 1975," S. 1357, "The Health Manpower and Shortage Area Assistance Act of 1975," H.R. 5546, "The Health Manpower Act of 1975," and S. 991, "The National Health Services Manpower Act of 1975."

With regard to S. 989, the Administration is pleased with the proposed expansion of the National Health Service Corps Scholarship Program. This program will provide student aid to substantial numbers of health professions students and will help us meet Federal responsibilities for health services delivery. We are also pleased that S. 989 would extend and modify the National Health Service Corps Program along the lines that we have supported.

We also support those features of S. 989 which would permit us to target scarce resources to deal with the serious imbalances in the geographic and specialty distribution of health manpower, particularly

physicians, and the need to improve professional productivity in the health sector through the increased use of paraprofessionals and auxiliaries.

We are also pleased that S. 989 endorses the basic principle that individuals who benefit directly from Federal subsidy should expect to repay the public the subsidy directly, or serve the public with the skills which they received at the public expense. While I strongly disagree with the final approach taken in dealing with this issue, we are encouraged that this basic principle is receiving recognition.

However, it is disappointing that S. 989 would continue to provide funding levels that are simply too high. S. 989 would authorize more than \$5 billion for the next five fiscal years. At a time when fiscal restraint should be a watchword, every effort must be directed toward targeting limited Federal resources to areas of greatest need. The authorization levels contained in S. 989 are not realistic. They do a great disservice to the potential recipients of the funds authorized by creating expectations that cannot possibly be met.

I would like to single out for attention four other aspects of S. 989. First, the bill would expand the amounts and categories of schools eligible for capitation subsidies. We are seriously concerned that the general taxpayers--by means of his Federal taxes--will be called upon to subsidize in perpetuity the professional training of physicians, dentists, and other well-paid health professions. Such Federal subsidies are unnecessary to elicit adequate numbers of students for schools, which today accommodate only one out of every two to three qualified applicants. Also, under the higher grant levels and broader eligibility, practitioners would reap an inordinately high return on their own investment in their education. This Subcommittee should examine the social equity of these features of S. 989 and provide for a gradual phase-out of capitation along the lines suggested in the Administration's manpower proposal.

Second, the bill would establish a domestic "health professions draft" and compel two years of service from every selected student graduating from the entire range of health professions schools receiving capitation assistance. This requirement could mean

that in the very near future the Federal government would have the responsibility for placing and monitoring the professional activities of thousands of individuals in the health system. We strongly oppose this provision and offer as an alternative the strengthening of the National Health Service Corps Scholarship program. The service required of recipients of Corps scholarships can be expected to adequately meet the health manpower needs of the Nation's health service scarcity areas. Compulsory service by potentially all health professions students is unnecessary and undesirable.

Third, S. 989 would impose a Federal regulatory scheme to control the numbers and allocation of training positions for graduate medical education and would institute a national licensure system for physicians and dentists. While we share the concern over geographic and specialty imbalances which give rise to these provisions of the bill, we feel that there is little basis for initiating this far-reaching regulatory mechanism at this time. The distributional and other problems to which these provisions are addressed are not sufficiently understood. It would be difficult to defend the distribution of residencies selected if the quotas established by the regulatory body lack sufficient basis. In our view it is unwise to impose such limitations until their impact could be assessed

and considered. We do not accept the proposition that Federal regulation of residencies is the answer. We believe that positive incentives should be tried before we turn to regulations which are difficult to revise or eliminate once they are set in motion.

We feel that the major problem in medical residency training is the imbalance between primary and nonprimary care. To overcome this problem we plan to increase significantly our support for primary care training, particularly at the graduate level, with residency support including stipends. We feel that the ability of such positive incentives to have impact is clearly illustrated in the remarkable growth in the demand for and support of family medicine residency positions in the last few years. This encouraging event leads me to conclude that we can achieve a better balance in the distribution of residencies without the total Federal control of graduate medical education proposed by S. 989.

As a final point, we strongly oppose S. 989's internal interference in the management of the Department through proposed restrictions on our ability to administer

the health manpower program on a decentralized basis. The reasons for our opposition are, first, that it would conflict with the Administration's general objective of moving the operating program management activities from Washington to the regions where people are most affected by Federal policies; and, second, the provision would seriously restrict the Secretary's general authority for administering HEW programs. We feel, therefore, that such a limitation is unnecessary and inappropriate, and strongly recommend its removal.

I would now like to comment on S. 1357 which is practically identical to S. 3585 which passed the Senate in the 93rd Congress. We recognize that S. 3585, as passed last year, reflected an attempt to reduce the total cost of the legislation and to remove a number of objectionable provisions contained in the Committee-reported version of the bill. However, the bill does not go far enough.

S. 1357 would require that 25 percent of all students enrolled, in all schools receiving capitation support, agree to serve for a minimum of two years in a medically

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underserved area. As I pointed out earlier in my comments on S. 989, we do not see this as the most desirable approach. We think that an expansion and strengthening of the National Health Service Corps will provide us with the tools necessary to affect the current geographic distributional problems. We oppose a domestic "health professions draft" whether that draft affects 25 percent of health professions students or all such students.

Further, S. 1357 reflects continued reliance upon capitation grant subsidies as a major means of financing health manpower education. Moreover, the bill would extend capitation grants to a new category of professionals--namely, schools of public health and graduate programs in health care administration--and continue capitation to pharmacy schools which we believe to be inappropriate as it involves pre-baccalaureate training. At a time when it is critical to restrain Federal spending and the President has stated that he would veto new programs, we opposed expanding Federal commitments to activities which could be considered more effectively carried out in other ways. That a school trains

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individuals who will work in the health area is not a sufficient reason for Federal subsidy. The question is whether a subsidy from the National government is needed. As a health career is one of the most attractive today in terms of employment prospects, it is inequitable to subsidize such training while not subsidizing training in all of the other more risky and less lucrative employment areas.

S. 1357 also contains language which would interfere with the internal management of HEW. As I pointed out when I discussed this identical provision in S. 989, we strongly oppose its inclusion in the bill.

Finally, I would like to comment on H.R. 5546 which recently passed the House. In developing that bill the House Committee made efforts to overcome problems which we expressed to the Subcommittee during hearings in February. We remain concerned with this bill and because of a number of basic provisions are unable to support the bill at this time.

First, although the House Committee attempted to scale down the spending levels authorized by H.R. 5546, the levels are still far in excess of the President's budget request for fiscal year 1976.

Second, while the bill would attempt to shift a larger share of the educational expense to the student--and we support this principle--the bill continues to rely upon capitation as the basic method for supporting health professions institutions. As I pointed out in discussing S. 989 and S. 1357, we feel use of this form of subsidy should be strictly limited to schools of medicine, osteopathy, and dentistry that are taking steps to resolve the geographic and specialty maldistribution problems which face this country's health care system.

Also, the bill would prevent the Secretary of Health, Education, and Welfare from delegating certain administrative authorities to the regional offices. For the reasons I offered, we oppose such a provision in the strongest terms possible.

Finally, I would like to comment on S. 991, "The National Health Services Manpower Act of 1975."

This proposed act clearly states that the distribution issues are of paramount concern and we share that view. Like our scholarship provisions, S. 991 would address the geographic distribution problem through scholarships for service. However, whereas we envision about 25 percent of all students participating in this program, S. 991 would make such support available to all eligible students.

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If 90 percent of our graduating health professionals agree to the service conditions of the bill, a high proportion of suburbia would soon have to be identified as underserved for purposes of fulfilling the agreement called for in S. 991. While the geographic problem is real, the magnitude of the solution suggested in S. 991 is clearly excessive. Moreover, the payback provision for the substantial Federal support received, that is, six months of service for each year of support, is far too short. In our view, the Administration's proposal for a scholarship program, and continuation of the National Health Service Corps effort are more appropriate actions.

Both our bill and S. 991 would address the problem of medical specialty distribution by concentrating on the graduate training phase. Generally current health insurance coverage inadequately covers outpatient care and associated primary care training. To overcome this problem, we plan to significantly increase our support for primary care training particularly at the graduate level.

The ability of positive incentives to have an impact is clearly illustrated in the remarkable growth in the last few years in the demand for and support of family medicine residency positions. As you may know, during the past year the number of individuals desiring first-year residency places in family medicine exceeded the number of available place by approximately 1,000. This occurred at the same time that the number of first-year places increased by almost 50 percent. This encouraging event leads me to conclude that we can achieve a better balance in the distribution of residencies without the total control required by S. 991. Also, as I pointed out earlier, more study needs to occur and more data developed before we set far-reaching Federal control mechanisms in motion at this time.

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National Health Service Corps

Mr. Chairman, I would like at this time to turn our attention to the National Health Service Corps. As I mentioned earlier, we are pleased to note that S. 989 would extend and modify the National Health Service Corps Program and the NHSC Scholarship Program along the lines that we have supported.

The current one year extension of this program through the provisions of P. L. 94-63 covers several of the points also contained in the major legislative proposals now before the Congress, including the Administration's own proposal S. 1753. The particular proposals enacted by P. L. 94-63 pertain to pre-operational grants, the disposition of Federal property at NHSC sites upon the termination of Federal assistance, third-party payment collections, and of course the authorization of appropriations.

The Administration's National Health Service Corps proposal is embodied in S. 1753, introduced by Senator Schweiker, while our proposal for the NHSC Scholarship is contained in S. 996. Because we believe that the scholarship program is an integral part of our

assistance to medical education, we believe that this activity should more appropriately be considered in conjunction with the health professions' legislation, not in a separate bill along with the National Health Service Corps management provisions.

We believe that overcoming geographic maldistribution is one of our major problems. The NHSC/PHS scholarship program is our major means of encouraging more medical students to work in underserved areas. The program provides up to four years of financial support in return for a commitment to serve in the NHSC or in other PHS programs. Medical students agree to serve one year for each year of support, with a minimum of two years of service. S. 996 would extend this program through FY 1977. The 1976 budget request included \$22.5 million for the scholarship program in FY 1976. This compares with the \$3.0 million appropriated in FY 1974 and \$22.5 million appropriated for FY 1975.

The National Health Service Corps is a good example of a most productive and challenging program

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administered by the Department. Few programs within DHEW embody the potential for producing such a direct effect on health care in scarcity areas as the National Health Service Corps. The Corps program was implemented to decrease geographical health manpower shortages and to provide vitally needed health care among populations which lack health services. Within the four years of its operations, the National Health Service Corps has made notable impact upon hundreds of thousands of people and the health care they receive. Its effect has been felt in cities, towns, and remote rural areas--among people of diverse ethnic backgrounds and economic status. Despite the differences among the people who have been served by the Corps, they all shared the need for health professionals to bring them the health care they require and to assure them of the quality of health to which they are entitled.

We in the Department view the achievements of the Corps with pride and I am sure that you also within the Congress share this sense of accomplishment. The successes of the Corps have not been without certain

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difficulties and in recent months these difficulties have increased rather than lessened. The economy will certainly have an effect upon health professionals as they select locations for practice, and the loss of physician draft undoubtedly had an effect upon Corps recruitment efforts. Nevertheless, during the last year the Corps has recorded noteworthy successes.

First of all, we have now designated a total of 769 counties and areas as critical health manpower shortage areas eligible for NHSC personnel support. This figure is up 111 from the total of 658 areas designated during 1974. Area designation represents, of course, the first step in Corps efforts to bring health services to these areas. More significantly, as of July, 1975, a total of 270 communities with more than 670,000 persons were being served by NHSC assignees. During this year the Corps has approved a total of 465 of the designated sites for staffing.

A major contributor to NHSC success has been the attention and detail given to recruitment efforts.

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We have completed visits to over 100 medical schools and more than 250 house officer training programs. In additional direct contact efforts, we have conducted two special mailings to some 52,000 house officers. These recruitment activities have been conducted in an integrated effort with the Indian Health Service and the Bureau of Medical Services. During 1975, over 9,000 physicians and dentists have so far requested information on the Corps.

As a result of these efforts, the Corps increased the number of physicians and dentists recruited from 14 in 1971 to 247 during the past year. Because of these efforts we have continued to increase the number of professionals placed and we are happy to report that during the current calendar year a total of 315 physicians and other health care personnel were assigned. In addition, the Corps has experimented successfully with physician extenders. These include nurse practitioners and physicians' assistants. At the present time 146 of these health professionals are providing services at shortage areas through the Corps. Important side benefits of these

recruitment and placement activities include the attraction of health professionals other than Corps assignees to these shortage areas and the generation of economic benefits within the entire community served. At present over 1,200 support personnel--that is individuals above and beyond the actual health professions personnel--are being financed from site third-party and cash receipts. This represents a ratio of about two support personnel for each Corps assignee.

The data bank on community health manpower resources which we have developed serves as an important tool in bolstering Corps recruitment and placement efforts. Data on every designated scarcity area are available to facilitate the matching of Corps assignees with communities. Each candidate chooses between a number of sites in two or more regions which most closely parallel preferences of the applicant. This process is repeated until satisfaction with the possible choices is realized.

During the current year we have completed over 500 matching site visits. As a result of this effort--the basic principle of which is to assure permanency of

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site staffing--the newly recruited personnel will enlarge currently placed field staff to more than 325 physicians and over 200 additional health professionals serving in 270 critical shortage areas.

At the community level, one of the most important Corps efforts is to assist community groups in establishing programs linking assignees with other health provider resources. These efforts, which foster improved systems of care and develop professional and personal relationships, will greatly improve the possibility that Corps assignees will remain in communities beyond their assignment periods. The Corps retention rate this year is 30 percent, a significant increase compared to the 25 percent rate in 1974 and a mere 3 percent during 1973. Due to improved matching, recruitment of physicians completing their residencies, and increased community assistance activities to form services linkages, we have reason to anticipate an even higher rate during 1976.

The Department's concern about health care in rural areas is expressed through the Rural Health Initiatives.

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The several programs within the Bureau of Community Health Services actively participate in this effort and these efforts are strongly reflected in Corps activities. For its part of the rural health initiative the Corps has assigned 146 physicians and other health care personnel in 47 sites. These sites combine the manpower recruitment benefits of the Corps with the delivery system advantages of the Community Health Center concept and extend these services to various rural populations including migrant and seasonal agricultural workers.

The Corps additionally maintains a keen sensitivity to the complex problems of extending its services to urban populations. During fiscal years 1976 and 1977, the NHSC will initiate urban health care demonstration projects in five cities. The Department is aware that many previous efforts to serve urban areas have failed to achieve independent, economically self-sufficient practices. The Corps urban projects will seek to prove that through proper sponsorship, organization, and location, the goals of independence and self-sufficiency can be realized.

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This effort will encompass five major goals: (1) the provision of services for a cross-section of the population, though essentially targeted to underserved areas; (2) economic self-sufficiency; (3) the retention and continuity of providers beyond the life of the demonstration projects; (4) recouping the Federal and community investment; and (5) realization of economic goals while maintaining a system of quality care.

In another important area of assistance to the communities served by the assignment of NHSC personnel, we have substantially increased and upgraded the technical assistance provided. The areas covered by this assistance are application development; practice policies; facility, equipment, and supplies; staffing and personnel; office management; medical records and quality assessment; financial management and budgeting accounting and reporting; and public relations.

One of the most tangible results of this increased and improved technical assistance can be demonstrated in the recovery of NHSC billings. During the fiscal years 1972 and 1974, the Corps billed \$3,554,742 and collected \$2,615,122. During fiscal year 1975 alone

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we billed Corps sites a total of \$2,048,247 and collected \$1,062,814, with the results of the most recent billings not yet fully realized. The collection ratio will increase as payments are received from the May-June billings.

Moreover, by the end of the fiscal year in June, 48 of the total number of 268 supported sites had become fully financially self-sustaining.

The ultimate goal of the Corps is the reduction in the number of critical health manpower shortage areas through the establishment of independent practices. At the present time 60 sites have become independent and we expect this number to increase to nearly 100 by July 1976. Toward this end, we have analyzed existing legislation to determine which elements would enhance the realization of the major goal. We feel that three important legislative changes would facilitate the development of stronger local capabilities leading to independence from continuing Federal support in the majority of sites.

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One of the most important observations we have made relates to the problem of cost recovery during the initial stages of an entity's development. Sites presently must pay for the services received through the Corps on the basis of a cost recovery formula. The existing formula seriously limits flexibility during the start-up period of practices, the time when utilization and billings may be low and at a time when the community is assuming the overwhelming burden of start-up costs. Many practices typically incur large debts during the first six to 12 months of operation. These early debts encourage a tendency toward continued Federal support. The Administration's proposal, incorporated in S. 1753, would provide flexibility in cost recovery during a site's initial development period and would enable communities to avoid large initial operating debts. Easing the burden of such responsibilities during this critical period will enable communities to direct financial resources toward the development of programs that would expand and enhance the overall health care capacities of the community.

Closely allied with these financial problems are the other community needs associated with starting a health care practice within a community which lacks, either totally or partially, adequate health manpower resources. At the present time the Department conducts preliminary surveys of needs and helps the communities prepare for the arrival of Corps assignees. Most of these functions could be accomplished through local personnel resources. However, the existing legislation does not authorize the transfer of DHEW funds to the community for such purposes. In the most instances the needs for such funds are not great and the task could be accomplished with only a small investment of outside money.

Another problem area which has caused considerable difficulty, with both the Federal government and with the communities receiving Corps assignees, concerns the transfer of Federal equipment and supplies purchased with Federal assistance funding. This equipment is valuable to the communities for the delivery of health care, but represents only

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minimal worth to the government. We are, therefore, proposing that DHEW have the authority to simply make a clear transfer of equipment and supplies to the nonprofit entity providing services to the community. This transfer would be prescribed by regulations and we stress the fact that title would not go to the health practitioner and that no buildings or facilities would be involved, only equipment and supplies. Under such a provision the community would benefit from the receipt of the equipment and the Federal government would realize the economy of a simple and clear method of transferring property.

We share the spirit of other proposals which would in effect accomplish this basic goal. However, S. 989, S. 991, S. 1357, and H.R. 5546 require that the equipment be sold at a fair market value. This can prove to be inefficient and cumbersome and creates yet another impediment toward site independence. We therefore encourage the adoption of the Administration's approach as expressed in S. 1753 and in P.L. 94-63.

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One of the distinctions in S. 1753 concerns the use of the term "critical health manpower shortage areas." S. 989, S. 1357, S. 2174 and H.R. 5546 speak to this problem in terms of medically underserved areas or populations . Although we do not wish to engage in a semantic argument, we do feel that there is a clear distinction involved. Corps activities are directed to the problem of availability of health manpower resources. The use of the term medically underserved areas for the Corps programs could result in confusion with the focus of other programs in the Department such as the HMO or Community Health Center programs. By clearly distinguishing health manpower shortage areas, we would hope to escape confusion regarding shortages of actual health manpower in contrast with other shortages such as transportation, organization, or delivery of services, or with financial barriers.

We believe that the Corps resources should be used where the fundamental health problem is one of critical manpower shortage and should not be used as mechanism to solve other health service problems where the manpower resources are available.

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Finally, one of the notable differences between the Administration proposal and others before this Subcommittee including S. 989, S. 1357 and H.R. 5546, concerns pay incentives for physicians and dentists. These do not appear in our own proposal because we feel that such incentives overlap provisions contained in Public Law 93-274. Additional incentives would create unfair salary differentials for Corps assignees in comparison with other PHS personnel stationed in critical shortage areas such as those of the Indian Health Service. We feel that they are unnecessary, and we strongly oppose them.

Conclusion

In summary, Mr. Chairman, I strongly recommend enactment of the Administration's health manpower proposals. These proposals on the level of Federal support and funding mechanisms reflect a careful assessment of priorities and projections of health manpower. I know we can move forward together in developing new health manpower strategy that is financially prudent and appropriately targeted.

We look forward to working with you and your colleagues on this important legislation.

Senator KENNEDY. The committee stands in recess.
[Whereupon, at 12:25 p.m., the subcommittee adjourned.]

HEALTH MANPOWER LEGISLATION, 1975

Foreign Medical Graduates

FRIDAY, SEPTEMBER 26, 1975

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:20 a.m., in room 4232, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy, Javits, and Beall.

Committee staff present: LeRoy Goldmon, professional staff member; and Jay B. Cutler, minority counsel.

Senator KENNEDY. We will come to order.

Over the past decade, thousands of foreign medical graduates (FMG's) have entered the U.S. medical system. These FMG's—attracted to the United States by hospitals seeking their labor, admitted to the United States under the exchange visitor program distorted from its original purpose of assisting the developing nations, and given priority for permanent immigration through a system which gives them preference—have created real problems in the quality of care and international relations areas.

This morning, representatives from the Sun Valley Forum, the Coordinating Council on Medical Education, and the Federal Interdepartmental Working Group on Foreign Medical Graduates will discuss the FMG situation, problems, and solutions.

The number of FMG's in the U.S. health care system has increased dramatically over the past decade. In 1973:

Of all U.S. physicians 21 percent were FMG's; in seven States, more than 50 percent of all doctors were FMG's.

Of all new medical licenses 44.5 percent were issued to FMG's; in 16 States, more than 50 percent of all initial licenses were granted to FMG's.

Of all physicians in internship and residency training 33 percent were FMG's; in seven States, more than 50 percent of all interns and residents were FMG's.

Existing U.S. policies and programs have resulted in a continuous and significant increase in the number of FMG's entering the United States. This situation has now progressed to the point that almost half of all new U.S. physicians are FMG's.

This large-scale influx of FMG's poses problems in two areas—quality of medical care and international policy.

Questions concerning the quality of medical care provided by FMG's are based on the fact that these physicians did not attend accredited U.S. medical schools.

These physicians have not been educated in the system with which we are familiar and in institutions which have been reviewed and accredited as are the schools of medicine in the United States. We cannot depend upon the quality of their education as we can on the quality of education provided to the graduates of accredited U.S. schools.

For these physicians, in fact, the United States has substituted a single examination, that offered by the Education Council for Foreign Medical Graduates, ECFMG, for the rigorous competitive admissions and preclinical and clinical training process which U.S. medical graduates must complete. No test, of course, can compare with the continuing competition and socialization that U.S. graduates face over 8 years of premedical and medical training.

But, beyond that, it is clear that the ECFMG examination itself is inadequate. It is simply too easy. Ninety percent of U.S. medical graduates who take parts I and II of the National Board Examination pass. In comparison, of the FMGs who pass the ECFMG examination, it is estimated that only 20 percent could pass parts I and II of the National Board Examination.

An exacerbating factor in the quality of care area is the failure of many FMG's to speak good English. Medicine is an art as well as a science. Intrapersonal communication is essential to proper diagnosis and therapy.

While the ECFMG examination does include an English language section, it is a very easy written examination which does not truly test the ability of an individual to communicate in English. In this case, even an FMG who might be scientifically competent—who could pass parts I and II of the National Boards—might still not be a competent physician in an American setting.

A second problem raised by the large influx of FMG's lies in the foreign policy area. It is that the United States, the wealthiest and most technologically advanced Nation in the world, has, in recent years, imported almost one-quarter of all medical school graduates outside of the United States and the Communist nations.

In the developing nations, of course, from which more than 90 percent of FMG's currently entering the country come, there are millions of people without adequate medical care. Basic medical services—immunizations and rudimentary public health services—are lacking in vast areas. Tuberculosis, schistosomiasis, even smallpox, still afflict the citizens. Yet, thousands of doctors from these nations have left these countries to come to the United States.

Foreign nations have expressed their opposition to the immigration of many of their physicians. In 1967, the India Government prohibited the further administration of the ECFMG examination on its territory. Ceylon, faced with a threat of a major outbreak of polio in

1971, was forced to take emergency steps to halt the outflow of physicians, including the denial of exit permits to physicians leaving to take jobs abroad. And the Government of South Korea is attempting to control physician emmigration.

So the current situation must be changed. New policies must be adopted. We must insure that all physicians who provide care to U.S. residents are competent and can communicate in the English language. We must insure that foreign physicians who come to the United States to be trained to care better for their own people, return, in fact, to provide that better care.

Over the past year, since the subcommittee last considered this subject, a number of groups in the United States have reviewed their own position on this matter. Today, three groups which have conducted extensive reviews of the problems and possible solutions will present their recommendations.

These groups are the Sun Valley Forum, a private foundation sponsored organization, which brought together a number of experts for a week of focused discussion last February; the Coordinating Council on Medical Education, the group which coordinates the medical education activities of the AMA, AHA, AAMC, ABMS, and CMSS; and the Federal Working Group on Foreign Medical Graduates, an ad hoc committee made up of representatives from the Departments of HEW, State, Labor, Justice, and the Veterans' Administration.

All of the three groups which will appear before the subcommittee today have studied the FMG problem in depth and have published reports. These reports have considered the problems in detail and have made recommendations for policy changes in detail.

While the details in the three reports are not, in every instance, identical, the important factor is that the effect would be the same—the alleviation of the major problems in this area.

Certainly, from among the recommendations presented today, and from recommendations from individuals and organizations who will not be present today, a new policy concerning foreign medical graduates, one which alleviates our major problems can be developed.

We want to welcome our first panel this morning, consisting of three participants from the Sun Valley Forum on National Health.

The Forum was founded in 1971 to pursue educational activities concerning various aspects of health care.

I would like to welcome Richard Berman, Assistant Dean, Cornell University Medical School; Paul Feldstein and Patrick Ongley.

We will hear from Mr. Berman first.

STATEMENT OF RICHARD A. BERMAN, ASSISTANT DEAN, CORNELL UNIVERSITY MEDICAL SCHOOL, NEW YORK, N.Y., ACCOMPANIED BY PAUL FELDSTEIN AND PATRICK ONGLEY, M.D., ON BEHALF OF THE SUN VALLEY FORUM ON NATIONAL HEALTH, INC.

Mr. BERMAN. Thank you, Senator.

In the interest of time, I would like to submit my statement and report from Sun Valley Forum for the record and quickly try to highlight some of the facts as we took a look at them in the group.

I would like to make a disclaimer.

The report was reviewed by all participants, but it was not necessarily subscribed to by all participants in every statement. So the opinion that I am giving you is mine as it coincides with the report and does not represent the Forum, Inc. position, nor New York Hospital, nor Cornell University Medical College.

Senator KENNEDY. We will include the report as part of our record so the members of the committee will be able to examine it for the benefit of the conclusions.

Mr. BERMAN. At this point, I just want to highlight this.

As of December 31, 1973, there were 71,335 FMG's known to the AMA in the United States. FMG's now account for 20 percent of the total number of physicians—366,379—in the United States.

The number of FMG's entering this country annually has increased from 1,040 in 1954 to 12,285 in 1973, greater than the total of U.S. graduates, 10,391, in 1973.

FMG's now fill one-third, 18,400, of all internship and residency positions. The countries from which foreign-born FMG's originate have changed. During the 1950's, proportionately more FMG's immigrated from Europe; in 1957, Asia accounted for less than 8 percent of immigrating FMG's. As of 1973, two-thirds of FMG's were immigrants from Asia.

Currently, 1973, the largest number of FMG's are coming from India, the Philippines, and Korea.

We tried to take a look at the problem as related to four or five issues, the first of which was brain drain and immigration policy.

I think it was the feeling of the Forum that, as applied to physicians, the exchange visitor program of the United States has become subverted and there is some need to change it so, in fact, it would be a vehicle for providing graduate education to students from abroad to use in their homeland and not to stay here.

We looked at the areas of quality of care performed. It was important to note that the FMG's are not a homogeneous unit, and that generalizations about them in total are fragile. There are strong arguments for establishing controls over the total number of residencies offered, in order to adjust them to health needs, to impose budget limits on graduate resident reimbursement, to relate graduate programs to undergraduate medical school output, and assure that residencies have a high educational component—

Senator KENNEDY. If you could just pause for a minute.

We want to welcome Senator Javits to the committee.

Please continue.

Mr. BERMAN. There are some strong reasons to believe that the residencies should also be allocated and reallocated from time to time, among specialties in accordance with the needs of the medical care system of this country.

The Coordinating Council on Medical Education could develop into a mechanism through which this allocation could be made, but only if this organization develops effective arrangements for public accountability.

Senator KENNEDY. I do not know how long Senator Javits is going to be able to remain with us because he has other meetings. I know there is one particular area he is very interested in, and that is what kind of policy we are going to have toward American foreign medical school graduates coming back to the United States.

I know this is a matter that he is particularly interested in. All of us are. I know you are going to come to that, but I wonder if you can talk about that now.

Mr. BERMAN. We felt that the arbitrary reduction of residencies alone was not the best way to deal with the question of foreign medical graduates: Unless coupled with other regulatory steps, it is not a sufficient means to address the question of improving quality standards.

An effective and appropriate approach for dealing with the FMG quality question requires several steps. First is the development of a single evaluative procedure to be administered to all applicants for graduate medical study, whether the applicants have attended undergraduate medical schools within the United States or abroad, and whether the applicants are from the United States or abroad.

Special educational supports should then be provided to FMG's to fill in gaps in their medical training and to provide assistance in overcoming language and cultural barriers.

All FMG's coming to the United States for graduate training should be limited to approved residencies. And during these residencies, FMG's should be intermingled with U.S. peers and not be concentrated in FMG groups in particular hospitals or particular specialties within a hospital.

Any further validated quality controls should apply to all physicians equally.

If we are seriously concerned as to the quality of care actually performed by persons in the medical care system, the right approach to the answer is to create evaluation and review mechanisms that apply equally and periodically to all practitioners, not just FMG's.

In addition, mechanisms are developing, such as mandatory remedial continuing education, relicensure exams and, if needed, specific permits limited to specific kinds of care.

The current debate about the FMG and the doubts raised about the quality of care he provides have served to highlight the general need for improving quality controls of all physicians and other health practitioners.

As to Senator Javits question, there are concerns about the U.S. applicants to undergraduate and graduate medical schools.

We did recognize there was a special problem with regard to the more than 6,000 U.S. students who are now studying in medical schools abroad. We felt two lines of approach are required to deal with it.

First, as to qualified students who are already abroad, special efforts should be made, within the limits of the capacity of the Nation's medical schools, to bring these students back into the U.S. system as early as possible.

To bring this about for these students, it is desirable to increase the number of positions in the U.S. medical education system and to increase the number of points in the system through which entry can be made, as through programs like COTRANS or the "Fifty Pathway."

Second, it should be made clear that for any students who enroll in a foreign medical school after a near fixed date, these special programs will not be available, and U.S. students who study medicine abroad will thereafter be admitted to graduate medical study in the United States only by meeting the same academic standards as foreign-born FMG's.

Senator KENNEDY. Do you have specific recommendations in terms of how we bring them back into the U.S. medical education system?

There have been some suggestions that we should use a fifth year and there are other proposals.

Do you have any specific ideas about what should be done?

Mr. BERMAN. I think the group favored both expansion of the fifth pathway and COTRANS method. We did not pick one or the other.

I think it was important to get as many of them back as quickly as we can.

The future entry of FMG's into the U.S. medical care system and the graduate training of FMG's in the system should be governed by the procedures and principles recommended——

Senator KENNEDY. Is it your position that we ought to do it just one time or do it on a continued basis?

Mr. BERMAN. Our feeling was that the immediate obligation we had was for the students now over there because a pattern has been developed, but that it be made clear that it not be an ongoing and continuing program.

Senator KENNEDY. So, they would have to take their chances with anyone else after this period of transition. Why do you feel that way? Why not continue it?

Mr. BERMAN. We felt that the United States ought to develop the capacity to meet its own medical care needs. We ought to figure out the numbers and types we need and produce them here at home and not rely on foreign medical personnel to meet our manpower needs.

Senator JAVITS. We do not have the ability now and will not have it for sometime, and one cannot be cavalier about that, is that not true?

Mr. BERMAN. Absolutely.

Senator JAVITS. Is not Senator Kennedy right, then, that you should work out some phased program, in phase with either the expansion of U.S. facilities to educate and train physicians or whatever alternatives, like ancillary and supportive physician personnel, and so on, that we are trying to develop? Thus, some planned phasing would seem to be indicated rather than, as you say, well, we will take care of these fellows there now, and that is it. Would you not agree that it cannot be if your facilities are not equal to the task?

Mr. BERMAN. Absolutely.

Senator JAVITS. Could you submit to us then some such plan or criteria or would you suggest perhaps that even our subcommittee, chaired by Senator Kennedy, might work up a task force consisting of medical school deans and officials of the Government departments concerned with planning, et cetera, which will work out such a plan?

It seems called for, especially because of the inadequacy of the training brought to us by the so-called FMG's.

Mr. BERMAN. I think the latter is much more in order. I am not prepared, in terms of reporting to you from a conference that already took place, to add any more material, but I think your latter suggestion is much more in line with the intent of the conference and is really a necessary step so that, in fact, we do not cut off people from care in the interim.

Senator JAVITS. Thank you very much.

Mr. BERMAN. Again, to meet that shortage, we did feel that it was important for the United States to develop a program that assures that these and similar positions would be filled by graduates of U.S. medical schools, and other qualified health personnel through financial or other incentives or disincentives, including, if necessary, mandatory periods of community service. That we were afraid, as Senator Javits and Senator Kennedy raised, that merely limiting the flow of foreign medical graduates by reducing the number of training slots did not resolve the real concerns of the brain drain, quality distribution of health care services.

We said unless the reduction of inflow is accompanied at the same time with other substantial adjustments in our present medical care system, the Nation's most disadvantaged citizens will be the ones who will bear the brunt of the dislocations that would flow from that step.

Senator KENNEDY. What do you want to do about that?

Mr. BERMAN. Specifically we did not recommend a specific step. But I personally think that when we reallocate residencies we must develop priorities for the urban centers, overall geographical distribution, as well as a realignment among specialties.

Senator KENNEDY. Let me ask you this. If we improve the criteria, the testing device, tighten up the various procedures to assure greater quality in the FMG's so that we are sure of relative competency in comparison with a U.S. medical school graduate, how would you react to a proposal that any physician who comes in must serve in an underserved area for 2 or 3 years?

Would you have any reaction to that?

Mr. BERMAN. My first response is that as long as you do it for all students, so it is not a penalty for coming in, or a bonus for coming in, you certainly have answered the quality issue.

Senator KENNEDY. Do you have any feeling about whether this ought to be done? The FMG's have not been, for the most part, in the primary care specialties? They choose the specialties. Should we be more willing to bring in FMG's who will provide primary care?

Mr. BERMAN. I concur with your objective to get Americans into primary care. I personally think that it would be a mistake to allot

the less desirable styles of practice or less financially lucrative areas of medicine to foreigners and to reserve the other areas of medicine for U.S. citizens.

Senator KENNEDY. Doctor, I wonder if you could tell us a little about the quality of various medical schools that you have seen overseas? I think we assume there are some that are comparable to medical schools in the United States, and others are not.

What are your impressions on this issue? Can we assure quality by following the suggestions that have been made this morning?

Dr. ONGLEY. I think this is a broad question, Senator, because you have to look at different countries, and different schools within different countries. You take European schools, which have a long tradition of medical education, a great majority of these will have standards very similar in most cases to American schools.

However, if you look at the larger majority of medical graduates coming to the United States now, they are coming from Asian schools, 65 percent. So you need to look at these schools as a particularly large group.

Again, there is tremendous individual variation. If you take Hong Kong, Singapore, Malaysia, which are schools with British educational background, highly motivated Chinese population, with essentially a combination of British and American curriculum, these schools are first-class schools. But there is only one school in Hong Kong, one in Singapore, and two in Malaysia.

So you are dealing with a small group of schools. If you take, by contrast, the Philippines, where you have seven medical schools, and contribute about 11 percent of all foreign medical school graduates coming from four of those schools, and they contribute about 16 percent of all foreign medical graduates, in the Philippines there is only one government school with six private schools, and the one government school, which is the University of the Philippines, is a very good school.

Students enter by competitive examination, have good curriculum, good teachers. But then the private schools, by and large, vary in tremendous quality, some quite good, and some very poor.

You can carry this on into Indonesia, and Korea. The difference between one and two topflight schools, and a rather large number of other schools, well, there is tremendous variation in the quality of these schools.

You can see this if you look at the results of ECFMG exams.

Senator KENNEDY. Did your group make any recommendations about the size of the American medical schools? Did you urge greater expansion, or did you think the class size is now at about the right level?

If you see a reduction in FMG's, then you have to ask what is going to be the impact in terms of the numbers of medical school graduates here in the United States.

And are you satisfied that adequate numbers are being trained here? Those that are not unrelated issues.

Did your group reach any conclusion about that?

Mr. BERMAN. I do not believe we could reach a conclusion on this issue. The question of need for physicians may become a little clearer when we start talking about specialty reallocations and improved geographical distribution.

Mr. FELDSTEIN. All we did was talk briefly about some of the cost of expansion to take care of additional numbers of students to cover the number of FMG's that could be replaced by American students. Those costs vary of course, but estimates vary anywhere from \$10 to \$20 billion. It is fairly substantial to replace all FMG's by American students.

We did not go into the number of American students there should be.

Senator KENNEDY. As I understand, with a reduction in the number of FMG's McKinsey & Co. says by the year 2000, we will have 209 physicians per 100,000 population, and with a continuation of the current inflow of FMG's we would have 255 per 100,000 population.

Now, we are at approximately 174, 176. Do you have any kind of reaction to that? Obviously you are going to decrease the expansion.

The increase would be from 174, per 100,000, to 209, with a modified FMG program, or 255 without it.

Did you consider these alternative figures at all in making your recommendations?

Mr. FELDSTEIN. No, we did not. I have not seen the McKinsey report.

I am familiar with projections made far in advance, and it is difficult to always be accurate. An important point though is whether the American graduate is a substitute for the foreign medical graduate, where they go to practice, and who they serve.

It is not clear that if you get an increase in American graduates they will replace the population groups that the FMG may be serving. But I am not familiar with the projections, how accurate they are.

Dr. ONGLEY. Senator, I think those figures per 100,000 population are somewhat misleading, because it depends on what these doctors are going to do. If you have 200 per 100,000 population, you have one per 500 persons, and I think in Boston you have about one per 450.

You have to look at the distribution. You have to decide the purpose of the medical school, and is it turning out doctors to take care of the sick population, or to provide economic opportunities for a small group of people, or is it turning out large numbers of researchers, and I think with all these phases you just cannot put a number on them.

Senator KENNEDY. I think that is a fair statement.

I want to thank you very much.

I did have an invitation to go to that conference last January, and I wish I had been able to get there for a lot of reasons. I am glad to hear the report from it. I am sure they will be very useful to us. I want to thank you very much.

[The prepared statement of Mr. Berman follows:]

Prepared Statement Before the Subcommittee on Health
of the Committee on Labor and Public Welfare, U.S. Senate
on

The Foreign Medical Graduate
in the United States Health Care System

REPORT OF A SYMPOSIUM SPONSORED BY
THE SUN VALLEY FORUM ON NATIONAL HEALTH, INC.

by

Richard A. Berman

September 26, 1975

I'm Richard A. Berman, and I am the Assistant Dean at The Cornell University Medical School and an Associate Director of The Society of the New York Hospital. However, I am here today to report to you on The Sun Valley Forum on The Foreign Medical Graduate in the United States Health Care System. Mr. Bayless Manning, Chairman of the Board of the Sun Valley Forum, has asked me to convey his apologies and regrets that a prior commitment prevents his being here today.

The Sun Valley Forum on National Health is a non-profit educational organization incorporated in 1970 under the laws of Idaho. The purpose of the Forum is to work toward the improvement of the health of Americans and of the health care system. The Forum seeks this objective through educational activities--the sponsorship of symposia, conferences and lectures, and the preparation and publication of papers and reports. Governed by a board of directors of professional and lay leaders (named at the conclusion of these remarks), the Forum endeavors to carry out its programs at the highest possible level of excellence.

Activities of the Forum Center at Sun Valley, Idaho include symposia which bring together leaders and experts to share ideas and to review expert papers on aspects of the nation's health problems. Symposium participants include professionals in all health-related fields, as well as other persons associated with or interested in health. This has been made possible by grants from the Branta Foundation, Inc., the Janss Foundation, the Robert Wood Johnson Foundation, Aetna Life and Casualty Company, Boise Cascade Corporation, the Johns-

Manville Company, the Times-Mirror Company, the Mary W. Harriman Trust, and the U.S. Department of Health, Education and Welfare, Contract #N01-MB-44151.

In June 1971, the Forum devoted a major symposium to the financing of the nation's health care system. In June 1972, the Forum turned to the question of the organization of the health care delivery system. The 1973 symposium dealt with the provision of primary health care, and the symposium held in August 1974 reviewed Canada's experience with its national health insurance system. The January 1975 symposium dealt with the position of the foreign medical graduate in the American health system.¹

At the close of the January 1975 symposium, participants reviewed a final conference report. No one was asked to sign the Report, and it should not be assumed that every participant necessarily subscribes to every statement in it. But except where the Report indicates that a participant accepted the opportunity to dissent or to express a separate opinion, the Report represents the sense of the symposium. I may add that while my own remarks coincide with those views expressed in the Report, they should not be considered an expression of any position on the part of the Forum, Inc., Cornell

¹Sun Valley Health Forum publications include: "Report of Symposium on Personal Health Care and Financing," June 1971 (available from Sun Valley Forum); Medical Cure and Medical Care (251 pp., paper \$6.00, Milbank Memorial Fund, 1972), edited by Spyros Andreopoulos (available from PRODIST, Neale Watson Academic Publications, Inc., 156 Fifth Avenue, New York 10010); Primary Care: Where Medicine Fails (212 pp., cloth \$11.00, John Wiley & Sons, New York, 1974), edited by Spyros Andreopoulos, Foreword by Merlin K. Duval, M.D.; National Health Insurance: Can We Learn from Canada? (304 pp., cloth \$10.95, John Wiley & Sons, New York, 1975), edited by Spyros Andreopoulos, Foreword by Philip R. Lee, M.D.

University, or the New York Hospital.

All of you have been given a copy of the complete Report. We tried to look at the potential problem caused by the Foreign Medical Graduate from the following perspectives:

- A. Brain Drain and Immigration Policy
- B. Quality of Care Performed by FMGs
- C. U.S. Applicants to Medical Study
- D. Surplus of Physicians
- E. Social Equity and System Reform

Before highlighting the Report's conclusions and recommendations, let me review the factual context on which our considerations were based:

1. "As of December 31, 1973, there were 71,335 FMGs known to the A.M.A. in the United States. FMGs now account for 20 percent of the total number of physicians (366,379) in the United States. The number of FMGs entering this country annually has increased from 1,040 in 1954 to 12,285* in 1973, greater than the total of United States graduates (10,391) in 1973. FMGs now fill one-third (18,400) of all internship and residency positions. The countries from which foreign born FMGs originate have changed. During the 1950s, proportionately more FMGs immigrated from Europe; in 1957, Asia accounted for less than 8 percent of immigrating FMGs. As of 1973, two-thirds of FMGs were immigrants from Asia. Currently (1973), the largest

*A substantial number of these FMGs--perhaps 3,500--are not new entrants but persons switching over from non-immigrant to immigrant status.

number of FMGs are coming from India, the Philippines, and Korea.

"A substantial number of FMGs (7,143 in 1972) enter the United States directly as immigrants; of these, some do so with the assistance of two special 'occupational preference' categories. Most FMGs now in the United States, however, originally came to this country through a different channel. They were admitted on an exchange visitor (non-immigrant) visa, as part of a program intended to provide education to foreign students under the assumption that they would, on completion of their training, return to their countries of origin. Through a series of changes of law and regulation, some designed to facilitate immigration procedures, it has become increasingly easy for such students in the medical field to change the exchange visitor visa for a permanent resident visa. The typical FMG, therefore, is the graduate of a foreign undergraduate medical school who entered the United States to undertake graduate training in an internship or residency. Of FMGs currently in residencies, about 85 percent are in hospitals affiliated with medical teaching institutions and about 15 percent are in non-affiliated hospitals. In 1973, FMGs occupied 59 percent of all filled non-affiliated hospital residencies and 62 percent of all filled, non-affiliated residencies and internships.

"A significant number of FMGs, after completing their graduate training, sit for state licensing examinations, pass them, are licensed to practice medicine, and enter the general patterns of practice and geographic distribution of U.S. educated physicians. FMGs make up one-fifth of the faculties of the medical schools of the United

States. And one-half of the nation's Nobel laureates in medical sciences are FMGs.

"Some FMGs who are licensed (and perhaps a larger number of FMGs who find it impossible to gain licensure or full licensure) continue to serve on an essentially permanent basis as staffs to hospitals that are at a disadvantage in recruiting physicians, especially state mental hospitals, V.A. hospitals, and some publicly financed hospitals in the inner city. The hospital system in some states is heavily dependent upon FMGs for their staffing. New Jersey is the extreme example: 78 percent of the resident and intern staff in its hospitals is made up of FMGs; in the New Jersey mental hospitals, 13 percent of the physician staff is composed of FMGs who are not licensed to practice medicine. In other states, such as California, 7 percent of the state hospital staff is made up of FMGs but all have achieved fully licensed status.

"An unknown number of FMGs who entered the United States as legal immigrants have disappeared into the society as, it is feared, illegal medical practitioners, either unlicensed or only partially or temporarily licensed. The professional location and pursuits of a substantial number of FMGs, perhaps 10,000, is unknown.

2. "Between 6,000 and 7,000 U.S. citizens are known to be currently attending undergraduate medical school in countries abroad, particularly Mexico and Italy. The emergence of a substantial number of U.S.-born FMGs is of recent origin. Some U.S.-born FMGs have been able to transfer to United States medical schools after two years of medical study abroad under the aegis of a special

program called the Coordinated Transfer System (COTRANS) and another entry avenue known as the 'Fifth Pathway.' The vocational and career patterns of U.S.-born FMGs who return to the United States as interns and residents cannot yet be fully discerned, but it appears that relatively few of them are working in the state mental hospitals and inner-city hospitals where foreign-born FMGs are concentrated."

This, then, is the factual background, and the Symposium's conclusions and recommendations are as follows:

A. Brain Drain and Immigration Policy

1. "Freedom of movement of persons is a cherished American policy and United States immigration policy should not preclude a person from entering the United States on the ground that he is a physician. But planning for the nation's medical manpower needs should not be predicated on an assumption that there will be a continued inflow of FMGs in large numbers. Further, the United States should not actively pursue a policy that takes advantage of its economic strength to drain off limited human resources from developing countries. The occupational preference visas category status presently extended to physicians as immigrants should consequently be rescinded."

2. "As applied to physicians, the Exchange Visitors Program of the United States has become subverted over time; it has now become primarily a vehicle for generating services for

U.S. institutions and a vehicle for entry to the U.S. medical profession, rather than a vehicle for providing graduate education to students from abroad for use in their home countries. The original purpose of the Exchange Visitors Program, that of international educational exchange, should be reaffirmed, and the United States should cooperate actively with those countries of student origin that wish to have their students return to their homelands following graduate study in the United States.

"On grounds of both moral considerations and political realities, the United States and its medical educational institutions should provide assistance to developing countries."

B. Quality of Care Performed by FMGs

1. "FMGs are not homogeneous, and generalizations about FMGs as a group are fragile. Educational standards in some countries are higher than in others, and there are wide variations in competence among the graduates of any one medical school and among the graduates of different medical schools in any one country."

2. "There are strong arguments for establishing controls over the total number of residencies offered in order to adjust them to national health care needs, to impose aggregate budget limits for graduate residency reimbursement, to relate graduate programs to undergraduate medical school outputs, and to assure that residencies have a high educational component."

There are also strong reasons to believe that residencies should be allocated and reallocated from time to time among specialties in accordance with needs of the medical care system of the nation. The Coordinating Council on Medical Education could develop into a mechanism through which this allocation could be made, but only if this organization develops effective arrangements for public accountability and planning expertise. Arbitrary reduction of residencies, as some have proposed, is not the appropriate way to deal with the FMG problem. Unless coupled with other regulatory steps, it is not a sufficient or well-directed means to address the question of improving quality standards."

3. "An effective and appropriate approach for dealing with the FMG quality question requires several steps. Medical schools and testing authorities should move as quickly as possible to develop a single evaluative procedure to be administered to all applicants for graduate medical study, whether the applicants have attended undergraduate medical schools within the United States or abroad, and whether the applicants are from the United States or abroad. FMGs and all others will then be perceived as substantially equivalent when they enter graduate study. Special educational supports should then be provided to FMGs to fill in gaps in their medical training and to provide assistance in overcoming language and cultural barriers. All FMGs coming to the United States for graduate training should be limited to approved

residencies. During their residencies, FMGs should be intermingled with United States peers, and not be concentrated in FMG groups in particular hospitals or particular specialties within a hospital. Any further validated quality controls should apply to all physicians equally."

4. "If, of course, one were to proceed circularly by assuming that to be a 'physician' one must have undergone exactly the scientific and clinical training of the United States style of medical education, then it follows by definition that most FMGs, whether or not licensed, should not be denominated 'Physicians' since their education does not conform to that model. On the other hand, if health care is being provided by a person who is appropriately trained to do what he is doing, then the 'quality' of the service he performs is not in question. A substantial fraction of the current controversy about FMGs is not about quality, but revolves around the issue of whether a health practitioner with differentiated training who is performing a limited function should properly be allowed to call himself a 'physician' as the term is a priori defined in the United States (implying a particular educational background), or whether he should be denominated as some form of physician's assistant or associate.

"Moreover, the basic question of quality at issue is not one that is limited to FMGs, and FMGs should not be

made scapegoats for a deeper problem. Present U.S. testing methods seek to assess a physician's general professional competence only on entry into the profession and his specialty competence when he takes his certification examinations; such examinations do not and cannot undertake to assess the quality of care he later delivers, and do not assure its future quality. If we are seriously concerned as to the quality of care actually performed by persons in the medical care system, the right approach to the answer is to create evaluation and review mechanisms that apply equally and periodically to all practitioners, not just FMGs. The PSRO system will apply to all practitioners, including licensed FMGs. In addition, mechanisms are developing such as mandatory remedial continuing education, re-licensure exams, and if needed, specific permits limited to specific kinds of care. Future development in medical care quality control is likely to lie along these lines. The current debate about the FMG and the doubts raised about the quality of care he provides have served to highlight the general need for improving quality controls of all physicians and other health practitioners."

C. United States Applicants to Undergraduate and Graduate Medical Study

"A special problem exists with regard to the more than 6,000 U.S. students who are now studying in medical schools abroad. This is an unfortunate situation and two

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lines of approach are required to deal with it. First, as to qualified students who are already abroad, special efforts should be made, within the limits of the capacity of the nation's medical schools, to bring these students back into the U.S. system as early as possible. To bring this about for these students, it is desirable to increase the number of positions in the U.S. medical education system and to increase the number of points in the system through which entry can be made, as through programs like COTRANS or the 'Fifth Pathway.' Second, it should be made clear that for any students who enroll in a foreign medical school after a near fixed date, such as June 30, 1975, these special programs will not be available, and U.S. students who study medicine abroad will thereafter be admitted to graduate medical study in the United States only by meeting the same academic standards as foreign born FMGs."

D. FMGs, Social Equity and System Reform

"The only sound long-term resolution of the interconnected problems discussed in this Report involves a series of interconnected steps, some of which will be unpalatable and will call for pronounced changes from our historical practice.

"Three lines of approach are required, not one:

1. The future entry of FMGs into the U.S. medical care system, and the graduate training of FMGs in the system should be governed by the procedures and principles

recommended above.

2. The staffs of all U.S. hospitals should in the future be required to be composed of fully licensed physicians or other qualified and appropriately licensed health care personnel. (For a time, present staffs will probably have to be exempted from this requirement on a grandfather basis.)

3. As beneficial consequences of these steps, the educational quality base of FMGs will be upgraded, the quality of care in public hospitals and elsewhere will be improved, the role of the United States as a generator of medical brain drain from developing countries will be reduced, all applicants to graduate medical education will be treated evenhandedly, and the pattern of residencies will be rationalized and their educational quality enhanced. But the additional probable consequence will be that the flow of FMGs into the nation's medical system will drop off and the state mental hospitals and inner-city hospitals will experience a substantial shortage of physicians. To meet that shortage, the health care system of the United States must be modified so as to ensure that these and similar positions will be filled by graduates of U.S. medical schools and other fully qualified health personnel through financial and other incentives and disincentives, including, if necessary, mandatory periods of community service.

"As so often happens when we have grown accustomed to

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drawing upon an available low-cost resource, the ability of the United States to draw upon FMGs, and especially unlicensed or less than fully licensed FMGs, has tended to conceal and allow to persist the basic deficiencies in our medical care system. The apparently simple step of curtailing the inflow of FMGs by arbitrary legislation is illusory. Unless the reduction of inflow is accompanied at the same time with other substantial adjustments in our present medical care system, the nation's most disadvantaged citizens will be the ones who will bear the brunt of the dislocations that would flow from that step."

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Senator KENNEDY. Our second panel is from the Coordinating Council on Medical Education. Dr. William Holden, past-president of the American Board of Medical Specialties, is here this morning with representatives of the American Hospital Association, American Medical Association, Association of American Medical Colleges, and the Council of Medical Specialty Societies.

We are going to have to recess for a few minutes for this vote.

[Short recess.]

Senator KENNEDY. Dr. Holden, we will start with you.

STATEMENT OF WILLIAM HOLDEN, M.D., PAST PRESIDENT OF THE AMERICAN BOARD OF MEDICAL SPECIALTIES, ACCOMPANIED BY JOHN A. D. COOPER, M.D., PH. D., PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES; DAVID THOMPSON, DIRECTOR, NEW YORK HOSPITAL; DR. TOM NESBITT, SPEAKER OF HOUSE OF DELEGATES, AMA; DR. R. HANLON, DIRECTOR, AMERICAN COLLEGE OF SURGEONS

Dr. HOLDEN. May I introduce the other panel members?

On my far left is Dr. John Cooper, President, Association of American Medical Colleges. Next is Dr. David Thompson, Director of New York Hospital.

On my immediate right is Dr. Thomas Nesbitt, Speaker, House of Delegates, AMA, and immediate past chairman of the Coordinating Council on Medical Education.

On my far right is Dr. Hanlon, Director of American College of surgeons, President of the Council of Medical Specialty Societies, and Vice-Chairman, Coordinating Council, and all four are members of the Coordinating Council.

Senator Kennedy, I am William D. Holden, and represent the American Board of Medical Specialties, which is the central administrative agency for the 22 medical specialty boards recognized by organized medicine.

I am the immediate past president of that organization, and am presently a member of the executive committee. Other positions which I hold that are relevant to the subject being discussed here today are: Professor and director of the department of surgery, Case Western Reserve University, Cleveland, Ohio, and chairman of the committee on physician distribution of the Coordinating Council on Medical Education (CCME).

The CCME has as its parent bodies the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies. The council was established to bring together the separate segments of the medical profession to develop national policies applicable to all aspects of medical education. It has been in existence since January 1973.

The subject which I shall discuss today is a report on the foreign medical graduate that has been approved by the Coordinating Council and is in the process of review by the five parent organizations.

At the very first meeting of the Coordinating Council a commitment was made to analyze the complex problem of physician manpower in

this country. The committee on physician distribution was organized with appointees of the five parent bodies and one additional member representing the DHEW.

In viewing the problem of the specialty and geographic distribution of physicians, the committee on physician distribution was aware of the fact that no valid projections of need for physicians graduating from medical schools in the United States could be made unless attention was directed to the large annual influx of foreign medical graduates (FMG's). The subject has been studied in depth for 2 years and the FMG report resulted.

During the development of this report the committee consulted a number of experts in the Department of Health, Education, and Welfare and in the medical profession who were engaged in a variety of studies relevant to the FMG.

The issues identified in this report provide the basis of the 47 recommendations proposed. The most important of the issues are:

One: The need for better coordination of policies concerning the role that FMG's should play in the U.S. health care system.

Two: The preferential and flexible immigration policies that encourage large numbers of FMG's to emigrate to the United States.

Three: The wide range of professional competence of FMG's coming to this country which is a manifestation of the heterogeneous quality of their undergraduate educational programs.

Four: The appropriateness of the ECFMG examination to designate individuals whose competence can be equated with that of USMG's.

Five: The inadequacy of the examination for assessing capability to utilize the English language effectively.

Six: The service rather than educational aspects of many programs to which FMG's are attracted.

Seven: The estimated thousands of FMG's in this country who have never passed the ECFMG examination or who have never qualified for an unrestricted license to practice medicine.

Eight: The thousands of U.S. nationals attending foreign medical schools who have difficulty reentering the U.S. medical educational system.

General recommendations contained in the CCME report are addressed to:

One: The need for this country to be self-sufficient in providing the numbers and types of physicians required to meet the health care needs of the Nation.

Two: The desirability of this country's educational system providing assistance to foreign countries in order to improve their own systems of education and health care.

Three: Discontinuing preferential immigration status to members of selected health professions.

Four: The need for a qualifying process for the admission of FMG's to graduate programs that will demonstrate a standard of professional proficiency equivalent to that required of USMG's.

Five: A requirement that all physicians either have a full license to practice medicine or be formally enrolled in a program of graduate medical education.

Six: The need for formal orientation and educational experiences for those FMG's demonstrating a need for them.

Seven: The role of the CCME in formulating national policies applicable to the graduate education of FMG's.

Eight: The role of the liaison committee on graduate medical education (LCGME) in accrediting all programs in which FMG's are enrolled.

Specific recommendations were addressed in four different aspects of the subject of FMG's:

One: Temporary visitor physicians.

Two: Foreign nationals seeking permanent residence.

Three: U.S. nationals studying abroad, and

Four: U.S. assistance to medical education in developing countries.

The substantive special recommendations that relate to the general ones are that:

One: FMG's entering the United States on a temporary or exchange visa have demonstrated an acceptable standard of professional competence for assuming responsibility for patient care under supervision.

Senator KENNEDY. Is that parts I and II of the National Boards you are talking about?

Dr. HOLDEN. No.

Senator KENNEDY. Do you have any specific recommendations of how that should be done?

Dr. HOLDEN. Yes. Eventually, Senator Kennedy, I think there is a growing feeling among many organizations in voluntary medicine that there should be an assessment procedure applied to all physicians entering graduate education programs, or any patient care arena, whether U.S. medical graduates or foreign medical graduates, that would be a nondiscriminatory evaluation mechanism that would in essence insofar as we can devise one, predict the capability of an individual to assume patient care responsibility.

Senator KENNEDY. Is this an examination you are talking about?

The administration talked about developing an examination over the next couple of years.

Dr. HOLDEN. That is right. It is in the process of being developed, as a matter of fact.

Senator KENNEDY. Is that a proposal that you would support?

Dr. HOLDEN. That is a proposal that I think we all support, and that we do support the principle that people entering graduate education should be subjected to a single assessment procedure.

The exact nature of it is still in the process of being developed, but something to avoid discrimination, and also to have some kind of an evaluating mechanism that applies to all people.

Senator KENNEDY. You are not satisfied with the existing mechanism?

Dr. HOLDEN. No, not at all.

Senator KENNEDY. You do not think that guarantees the kind of standards which you find here in proposition one as "acceptable standards of professional competence?"

Dr. HOLDEN. That is right. We do not believe so.

Senator KENNEDY. Do you have any suggestion of what ought to be done in the interim, prior to the time that the new examination is developed?

Dr. HOLDEN. Well, the ECFMG examination is taken from National Board questions, but in essence it has amounted to a screening

examination rather than a qualifying examination. One temporary answer to improving the situation would be to reinforce the ECFMG examination, either by including more basic science, by changing the relative weight of the basic science and clinical science parts of this examination, and this at least to me individually would be the preferable way of temporarily resolving this problem.

Senator KENNEDY. Do you think that can be done expeditiously?

Dr. HOLDEN. Yes.

Senator KENNEDY. What is your feeling about part I and II? We ought to get that on the record.

Is it the fact that there could be young people trained abroad in medical schools of high quality, competent to practice first rate medicine, and yet they could be unprepared to pass this particular technical examination?

Dr. HOLDEN. Yes, they would be very difficult examinations to pass, Senator Kennedy. And I do not believe that these two examinations should be used. They are designed by the National Board of Medical Examiners to first of all relate to the whole stream of assessment procedures that leads to full licensure.

This is the primary purpose. They are qualifying, certifying examinations for licensure in this country.

The other relationship of these examinations issued to the schools of medicine in this country, they are given only to medical graduates or medical students in this country, and only exceptionally on request from the schools of medicine in this country that they be used.

And to use these examinations for any other purpose as a qualifying examination outside the medical school arena would distort the original certification intent of these examinations.

Senator KENNEDY. I see Dr. Cooper shaking his head over here. The thing that concerns me, as a lay person, is that these exams either are important in insuring that any young person who is going to practice medicine has the basic capacity to handle this type of information, or that they are not. I would think it is either important to being a doctor, or it is not important.

Can the young doctor practice first rate medicine? Can he or she do so without developing the expertise and competency of the kind that is required to pass these examinations? I suggest this raises the question of whether that is really important for these people to spend as much time as they are spending in medical schools, learning that kind of information. We have seen a lot of different issues raised certainly in this committee. For instance, the use of various drugs, a general lack of educational experience in terms of this whole area. And a number of ethical questions which are being raised by various kinds of human experimentation. And in a number of various kinds of issues.

I am wondering whether these issues—

Dr. HOLDEN. There are still things, well, first of all, I would agree in principle, that anybody involved, any school of medicine, or especially a graduate of any medical school, ought to be assessed in terms of its capabilities to take care of patients.

Now, the parts I and II, presumably do something of this sort, but to use parts I and II in a discriminatory fashion, and apply them only to qualifying examinations for foreign medical graduates would

immediately raise many legal questions about the use of these examinations in a discriminatory way.

If these examinations were applied to all medical students in this country, as well as foreign medical graduates, you could eliminate that. But it is not. It is a voluntary examination.

There are other screens for licensure in this country. There are many medical students in this country who, over 90 percent of them, do take parts I and II. But they are not required to take it, and many of them take it only upon the insistence of the school of medicine, and not as a certifying procedure for ultimate licensure.

Many American medical students, especially those who are not taking this for certification, fail these examinations. I think this would create an enormous problem for U.S. medical graduates, let alone foreign medical graduates.

Senator KENNEDY. Dr. Cooper, do you have a comment?

Dr. COOPER. I would just like to say in considering this examination which should be given to all students, it has been adopted by the association that parts I and II, or the FLEX examination should be substituted, with rebalancing of the scoring system to give more weight to the basic science areas of medicine.

This examination is given to students at the time they graduate from medical school—the part I and part II—and could serve in the interim period as an examination to better assure this country of the adequacy of the physicians coming in.

Dr. HOLDEN. Should I continue?

Senator KENNEDY. Yes.

Dr. HOLDEN [continuing]. Two: FMG's entering the United States on a permanent visa also be required to demonstrate the same minimal competence or have an unrestricted license to practice in a State or Territory of the United States.

Three: A minimally acceptable standard of competence be determined by the LCGME and be required of USMG's and FMG's alike.

Four: The U.S. Government, in consultation with the CCME, should aid in the development of appropriate agreements with other countries wherein the medical educational system of the United States agrees to provide specific educational opportunities in graduate medical education.

Five: Medical schools or other accredited health professional schools assume the sponsorship of exchange visitor FMG's coming to the United States for graduate medical education.

Senator KENNEDY. But not the hospitals—

Dr. HOLDEN. That is right.

Senator KENNEDY. Dr. Thompson, is there agreement on this?

Dr. THOMPSON. Well, the hospitals, generally speaking, and I think the teaching hospitals in particular, are primarily concerned with this, and would prefer to have, in addition to a statement upon sponsorship by accredited medical schools to include the phrase "and their affiliated teaching hospitals."

We had a long discussion of this recently at the executive council of AAMG, and there was agreement that that was desirable, because after all, that is where these graduate students, so to speak, are located, and that is where they will learn their profession.

We believe teaching hospitals should be included in that sponsorship.

Senator KENNEDY. But not the non-affiliated hospitals?

Dr. THOMPSON. No.

Dr. HOLDEN [continuing]. Six: The duration of graduate medical education in the United States of exchange visitor physicians be limited to 2 years subject to individual review.

Seven: Specific educational programs be devised for the exchange visitor physician that will meet his particular needs upon returning to his native country.

Eight: The exchange visitor physician be assured of a position in his own country upon return before being accepted in the United States.

Nine: The conversion of temporary visas to permanent visas be discontinued.

Senator KENNEDY. You mean we ought to work out arrangements with these countries to insure that the training that these young people would get would be related to their own country's particular needs? Is that the theme?

Dr. HOLDEN. Yes, primarily this is the theme. We provide educational experiences which, upon their return will improve their own educational environment services.

Senator KENNEDY. It certainly seems to me to make sense.

I would imagine in most of those countries, like India, the Philippines, other developing countries, that the training is going to be much more oriented toward public health than it is now.

Dr. HOLDEN. Right.

Ten: Preference or nonpreference immigration visas not be issued on the basis of occupation through blanket (schedule A) certification by the Department of Labor.

Senator KENNEDY. That is happening at the present time.

Dr. HOLDEN. Eleven: State legislatures and medical licensure boards adopt eligibility requirements and qualifying procedures for licensure that are uniform for all States and apply equally to USMG's and FMG's and that a minimum of 2 years of graduate medical education be required in a program accredited by the LCGME.

Twelve: Appropriate assessment procedures acceptable to the LCGME be devised as a requirement for all physicians entering graduate medical educational programs.

Thirteen: FMG's demonstrate an effective mastery of verbal and written English as a requirement for admission to graduate medical educational programs.

Fourteen: On an interim basis educational and orientation programs be devised to assist FMG's who have immigrated prior to January 1, 1976, and who have failed to qualify for approved residencies.

Fifteen: The coordinated transfer application system (Cotrans) be expanded to accommodate more qualified U.S. nationals studying medicine abroad.

Sixteen: The fifth pathway program be temporarily endorsed.

Seventeen: Eligibility requirements for entrance into graduate medical programs for U.S. nationals graduating from foreign medical schools be identical with those required for FMG's.

Eighteen: In a variety of ways the United States assist foreign countries, especially developing ones to improve their educational systems to meet their own health care needs.

Senator KENNEDY. Let me ask you: Should we alter our program to help medical schools move into these areas, the fifth pathway program and Cotrans? How necessary is that?

Dr. COOPER. Certainly the amount of effort required in the faculty for these students, well, roughly equivalent to what you would call for U.S. students, if you were ready to make up deficiencies and defects in their earlier education—

Senator KENNEDY. Have you worked out any proposals on this?

Dr. COOPER. On an interim basis, as Dr. Holden, suggested, we believe that if these schools are to be given this responsibility, there will have to be support for them.

Senator KENNEDY. Perhaps you can work something out, the panel can, and give us a recommendation on the dimension of the kind of assistance that would be necessary and your figures to justify that. It does seem to me if we are expecting medical schools to do this, and it seems to me to be worthwhile, then we ought to—we cannot expect them to do it, unless we are providing some kind of assistance.

Dr. COOPER. The executive council has adopted the policy that they should; that these should be time limited, so as not to encourage U.S. students to study abroad; and, instead of fifth pathway, which is just 1 year of clinical experience, that the Cotrans program be utilized by entering students as at an advanced standing in medical schools and permit more deficiencies to be corrected. That is the position, one which would require support, and we would be happy to provide you with some data.

Senator KENNEDY. We might do it for a period of time and find out how it works. If you could give us alternatives. I understand that the CCME supports a temporary transition program for those medical students now overseas. But, I think you may find—I know there are a couple of members of the committee and I am really open on the issue myself—who feel it ought to be more ongoing, at least for the period of time to see how it works. If you can give us some suggestions, if the decision is made to do it for a period of time.

Dr. COOPER. The concern is that our projections will exceed those that you made earlier in these hearings about the number of physicians. There are still new schools being opened that were not included in the recent projections. We think the ratio will be well above 200 physicians per 100,000 in the 1980's. The question is: Should we apply our resources to increasing the production of graduates by U.S. schools, rather than diverting those resources into the education and training of those who have spent some of their time abroad.

Dr. HOLDEN. Following the initial acceptance of this report by the CCME, an invitational conference was held under the sponsorship of the Coordinating Council, the Educational Commission for Foreign Medical Graduates, and the National Council on International Health. The 2½-day meeting held in Washington in April 1975 was devoted to a full discussion of the report. Invited to the conference were representatives of 25 agencies representing various segments of voluntary medicine. Included were representatives from two foreign medical graduate associations. In addition, invitations were issued to the Department of Health, Education, and Welfare; Immigration and Naturalization Service; Office of Management and Budget; the Civil Service Commission; Veterans' Administration; Subcommittee on Public Health and Environment of the House Interstate and Foreign Com-

merce Committee; Departments of State and Labor; Subcommittee on Health of the Senate Committee on Labor and Public Welfare; the Social Security Administration; the Committee on Appropriations; and their subcommittee related to health; the House and Senate Judiciary Committees; Social and Rehabilitation Service; and the Department of Defense. Most accepted the invitations. Several resource persons knowledgeable about detailed aspect of the FMG problem were invited and served as panel members in four different workshops.

The discussion at the conference was frank. While there were some suggestions for change, there was an overwhelming concurrence with the general principles and recommendations of the report.

Subsequently the CCME reviewed the report and incorporated most of the suggestions. Following approval by the CCME on June 5, 1975, the report has been delivered to the five parent bodies for their review and action.

The 47 recommendations contained in this report are directed to multiple agencies having some responsibility for the introduction of FMG's into the educational and health care system of this country. The objectives of the report are, broadly, to assure the people of this country that qualified FMG's are introduced into the educational and health care systems, that the experience of the exchange visitor physicians here will benefit their countries of origin, and that the United States will assist developing countries in their educational and health care problems. The principal agencies responsible for the implementation of these recommendations are the Coordinating Council on Medical Education and its associated liaison committees; the CCME's five parent organizations and the schools of medicine; teaching hospitals; the State medical boards; the Educational Commission for Foreign Medical Graduates; the National Council on International Health; the Congress; the Department of State, Judiciary, and Labor; and the Department of Health, Education, and Welfare. If generally accepted, the implementation of these recommendations should be carried out in a deliberate and sequential fashion in order to avoid any significant disruption of medical services presently being provided to the American people.

The problems related to the FMG cannot be resolved realistically or effectively by unilateral solutions. A coordinated effort on the part of all voluntary agencies and some sectors of the Federal Government is imperative if success is to be achieved. The problem of the FMG must also be resolved by all responsible agencies as a major component of any enlightened decisions concerning desirable changes in the specialty and geographic distribution of physicians.

We are grateful that representatives of the parent organizations of CCME have been invited to appear before you. The other panel members and I will be pleased to either elaborate upon parts of this report or answer questions.

Thank you.

Senator KENNEDY. Very good.

Are there any other points that members of the panel would like to comment on?

Dr. HOLDEN. The Council of Medical Specialties Societies has approved the basic report.

Dr. THOMPSON. Senator, the hospitals have some concern about the transition, as I am sure you have heard. For example, in New York

City in the public hospitals, which as you know are in the poorly served areas in many instances, about half of the residency positions are presently occupied by foreign medical graduates. We would hope that your committee would consider very carefully how to deal with that in transition. There is no question that we are all agreed that at the end of the line U.S. medical graduates should be the ones to take care of all the people. But that will take some time, as you have indicated. We do not know exactly how long or what the numbers are precisely, because things change. I would hope that there is some sort of a waiver or exception procedure included in any legislation which would take care of hardship situations because to strip these hospitals of a really very important part of patient care I think would not be in the best interest of the public.

So I do think and would hope that that legislation does include that. No disagreement as I say about the ultimate objective, but concern in the transition.

Senator KENNEDY. Dr. Cooper.

Dr. COOPER. May I ask, sir, that the written statement we have prepared be included as part of the record.

Senator KENNEDY. It will be included in its entirety.

Dr. Nesbitt.

Dr. NESBITT. Senator, the Medical Association is, in general, in agreement with most of the areas we covered. We, too, will have a supplementary statement to submit. It is in rough draft form and should be available within a few days. I think perhaps we should make some reference to some of the discussion earlier about the limitations of the examination process in the discussion we had relative to parts 1 and 2 of the National Board.

These examinations as related to graduates, whether they be United States or foreign born, or foreign trained I should say, are only one portion, perhaps not really the major portion in terms of assessment insofar as competence is concerned, whether they should practice medicine or assume care in a patient care center. I think we also have many questions, all of us do, about the accreditation process. I think we need to understand that accreditation of United States-Canadian medical schools is adequately carried out today by the Liaison Committee on Medical Education, and has been since 1942; and that it is virtually impossible to accredit with any degree of effectiveness the medical schools in foreign countries.

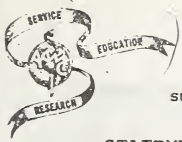
These are at least 400 of them. An attempt was made to do that, I believe, back in the fifties and it became virtually impossible to do so.

Senator KENNEDY. Well, I think the suggestions are very impressive, worthwhile, and useful to us. I think they may well form the basis for our actions on this particular problem.

You all have been very, very helpful to us. We are going, I am sure, to make some legislative changes, but I think you have been very, very helpful to us. You have clearly addressed an important question in terms of quality of health care in the country.

I want to thank you all very much. We look forward to seeing you next Tuesday.

[The prepared statements of the Association of American Medical Colleges as presented by Dr. Cooper and the American Medical Association, follows:]



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

STATEMENT BY THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ON FOREIGN MEDICAL GRADUATES
IN CONNECTION WITH HEALTH MANPOWER LEGISLATION*

Mr. Chairman and members of the subcommittee:

The Association of American Medical Colleges welcomes this opportunity to comment in the context of health manpower legislation on the subject of foreign medical graduates entering the United States. The medical schools, teaching hospitals and academic societies which make up the membership of the Association have had a long and continuing interest in this issue.

In the early 1950's, the Association joined with other concerned voluntary health organizations to explore ways to assure that graduates of foreign medical schools (FMGs) entering the United States for graduate medical education were adequately prepared to benefit from their education and training provided by residency programs. As a result of these efforts, the Educational Council for Foreign Medical Graduates (ECFMG) was established in 1957 to examine the credentials of those seeking internship and residency training and to administer examinations to assess their ability to participate in graduate medical education and training and their command of the English language. Certification by the ECFMG was adopted as a requirement for FMGs to enter approved internship and residency programs.

* Presented by John A.D. Cooper, M.D., Ph.D., President of the Association of American Medical Colleges, before the Subcommittee on Health of the Senate Labor and Public Welfare Committee, September 26, 1975.

The Association's interest in the FMG is further evidenced by the publication in 1969 of "Foreign Medical Graduates in the United States" by Harold Margulies of the American Medical Association and Lucille Stephenson Block of the Division of International Medical Education of the Association of American Medical Colleges. This was the first definitive study on the subject.

In August of 1973, the Executive Council of the Association appointed a task force on FMGs which issued its report, "Graduates of Foreign Medical Schools in the United States: A Challenge to Medical Education," in March of 1974 (Appendix A). The report became the basis on which the Association participated with other agencies through the Coordinating Council on Medical Education (CCME) in recommending national policy aimed at providing more appropriate guidelines for future action. The Association's Executive Council, at its meeting on September 19, 1975, endorsed all but three of the recommendations in the CCME report. It questions the wisdom of using the "fifth pathway" as a mechanism for United States citizens who are graduates of foreign medical schools (USFMGs) to gain admission to graduate medical education in this country, of devoting the ever less adequate resources of American medical schools to remedial education for FMGs, and not requiring that both the teaching hospitals and the medical schools sponsor trainees under the exchange student visa program. At the same meeting, the Executive Council reaffirmed its previously adopted position that the United States should make available in our medical schools the number of places necessary to meet the need for physicians in future years, so that under-

graduate medical education abroad not become a regular alternative to the study of medicine at home, and further recommended that the Association and its constituent schools must recognize that there are qualified students in the group studying medicine abroad. In the public interest, those who are qualified should be provided the same educational opportunities and recognition as their colleagues who entered U.S. medical schools directly. However, this will require additional resources so that qualified students can be selected by the faculty and admitted to advanced standing. Their level of admission should be determined by the policies of the faculty, and they should be provided the regular educational opportunity and challenge deemed necessary by a school's faculty for the awarding of the M.D. degree. Such programs would supercede existing "fifth pathway" programs.

The policies and programs for these transfer students should be subjected to the scrutiny of the accreditation process.

The seriousness of the current FMG problem is well documented in the study by Rosemary Stevens and Joan Vermeulen for DHEW ("Foreign Trained Physicians and American Medicine," DHEW Publication No. (NIH) 73-325, Government Printing Office, Washington, D.C., June 1972) and the CCME report, and need not be detailed here. In brief, by 1972, one-fifth of all physicians in the United States were graduates of foreign medical schools; one-third of all residents in U.S. hospitals were graduates of foreign medical schools, and almost one-half of all physicians newly licensed to practice were graduates of a foreign medical school. Fifteen years earlier, fewer than 6 percent of all physicians in the United States were graduates of foreign medical

schools.

Any consideration of the FMG issue must recognize the three distinct categories of the foreign-trained physician: (1) The one who comes to the United States for additional training and who expects to return to his home country to practice -- the exchange student; (2) the physician who comes to this country with the intention of remaining permanently; and (3) the U.S. citizen who is a graduate of a foreign medical school.

This consideration also should recognize the problems that would be caused by any abrupt change in the numbers of foreign medical graduates because of the positions they hold in the residency training programs. Any new program should provide for changes to be phased in to permit adjustments by the hospitals to avoid disruption of their services and programs.

The Association believes that the United States should continue to help less fortunate countries improve the level of their health care through appropriate education and training of their physicians. In meeting this commitment, the academic medical centers have provided residency training for tens of thousands of foreign medical graduates (FMGs). The rapid increase in the number of FMGs entering the country and their growing interest in remaining here instead of returning home raises serious questions about our current policies, particularly our immigration policies. We should not permit immigration to rob developing countries of badly needed health professionals.

The philosophy behind the student and faculty exchange programs is as valid today as it was when the original Fulbright-Hays exchange system was enacted. This interchange of ideas and

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knowledge should continue, as should the liberal immigration policies of the United States. However, the mechanisms established for this exchange should not become an instrument for depriving nations of their needed physicians. Therefore, the Congress should find ways to reestablish the clear separation of admission of exchange visitors for the sake of their education from the admission of immigrants who come primarily to establish permanent residence and secondarily for training as physicians.

The Association makes recommendations as follows, most of which are incorporated in S. 992, one of the bills under consideration by the Subcommittee.

Physician Exchange

Each of the three categories of FMGs mentioned above presents specific problems which should be dealt with individually. For the exchange visitor who seeks additional medical training, the AAMC recommends that, beginning July 1, 1976, the sponsorship of FMGs should be limited only to accredited schools of the health professions and their affiliated teaching hospitals.

The Association also recommends that the U.S. Government should facilitate agreements between the governments of other countries and their institutions and the individual components of the U.S. medical education system to provide specific types of graduate medical education for individual physicians who have been designated to fill key educational, governmental, or other professional posts in that country.

Before entering into such training, candidates selected for such educational experience in the United States would be required to meet standards of professional preparation established by the U.S. educational institutions and accrediting agencies; would be committed to return to their home countries on the

completion of the agreed upon educational program; and would be assured of previously specified academic, governmental or other professional appointments on their return to their home country.

Before the issuance of an exchange visitor visa, each FMG applicant should provide acceptable evidence of meeting the standards of educational attainment required by the sponsoring U.S. institution, demonstrate the potential to adapt to the cultural milieu in which he or she will be studying in the United States, as well as an effective mastery of the English language and, if the educational experience is to include training at the level of hospital residency, assurance of a minimally acceptable standard of professional competence for assuming responsibility for patient care under supervision.

The duration of graduate medical education in the United States for all exchange visitor physicians should be specified in advance of entering into such training, be limited in general to two years or less, and be subject to extension only on the request initiated by their governmental and institutional or agency sponsors, assuring them of employment on completion of the extended training period.

Amendments enacted in 1970 to the Immigration and Naturalization Act that permit exchange visitors to convert a temporary visa granted for educational and cultural exchange purposes to permanent immigrant status should be repealed. A change to permanent status defeats the original purpose of the visit, i.e., to improve health care in the visitors' home country.

The granting of H-1 temporary visas to FMGs should be restricted to foreign nationals of "distinguished merit and

ability" who have been invited by universities and other appropriate institutions and agencies to teach and to conduct research.

These Association recommendations would apply to the thousands of exchange visitor physicians who annually enter the United States. In many cases, exchange visitor physicians come from countries with severe physician shortages, and with poor records of personal health of the population. They presumably come to the United States for medical training unavailable in their countries, intending to return to their countries and practice. However, under authority of the 1970 immigration law amendments, many exchange visitor physicians seek to change their status to permanent immigrant, thus denying their home countries their newly acquired medical services. Few exchange physicians from India, the Philippines, Korea or Iran ever return. Again, this is essentially an immigration issue, and thus is best dealt with through immigration laws.

Immigrant Status

For the FMG who desires to enter the United States as a permanent resident, the Association recommends that he or she be treated as any other would-be immigrant. This would mean there would be no special preference given because of a medical degree, nor would there be any discrimination based on possession of a medical degree.

The Association recommends that only the "third preference" established under the 1965 Immigration and Naturalization Act Amendments (PL 89-236) be recognized in this category. This classification gives preference to admission to the country of

"qualified immigrants who are members of the professions, or who because of their exceptional ability in the sciences or the arts will substantially benefit prospectively the national economy, cultural interests or welfare of the United States."

The sixth preference should no longer be applied to physicians. This eligibility classification applies to "qualified immigrants who are capable of performing specified skilled or unskilled labor, not of a temporary or seasonal nature, for which a shortage of employable and willing persons exists in the United States."

The Association believes that a blanket declaration by the Department of Labor that a physician shortage exists nationally does not represent the true situation.

There are currently about 180 physicians per 100,000 persons in the United States. This number will increase to over 200 per 100,000 in the 1980's as a result of dramatic increases in medical school class sizes since 1968, even if immigration of FMGs ceases.

The main problem in providing adequate accessibility to health care lies not with aggregate numbers of physicians but in their distribution geographically and by specialty. Admitting FMGs does not contribute to the solution of this problem. They are distributed largely in metropolitan areas of states with the highest physician-to-population ratios. A greater fraction of FMGs than U.S. medical school graduates are hospital-based, non-primary care specialists. The argument that unfilled residencies are a valid justification for uncontrolled admission of FMGs is fallacious. The purpose of residency programs should be to provide graduate medical education and training and not to provide medical services.

U.S. Foreign Medical Graduates

For the U.S. student enrolled in a foreign medical school, the Association favors adoption of a plan whereby the qualified U.S. student enrolled in a medical school abroad can return to this country, be properly licensed and enabled to practice -- if the quality of medical education has been sufficiently high.

With adequate resources devoted to meeting the health needs of the nation's population, and with projected increases in numbers of U.S. medical graduates, undergraduate medical education abroad should not become a regular alternative to the study of medicine at home.

As previously noted, the Association recognizes that there are qualified students studying medicine abroad for which resources should be made available to make possible admission to advanced standing as determined by the appropriate medical school faculties. An alternate approach to the "fifth pathway" is needed because that method is at best disruptive of the educational process, and at worst it leaves the young physician without proper qualifications for licensure in all states by lacking certification from ECFMG and by not being a graduate of an accredited medical school.

This is especially important when considered in context of the number of U.S. students enrolled in this country and those in classes abroad. Present estimates place the number of U.S. medical students in foreign schools at about 6,000 or one-tenth of all U.S. medical students. One method designed by the AAMC and the National Board of Medical Examiners to help these physicians

continue their training, after graduation, in the United States is the Coordinated Transfer Application System (COTRANS).

In its first year of operation, 1970, 600 students applied for COTRANS sponsorship. By 1973, this number had reached 1,905, for a four-year total of 5,413, as reported in the Journal of Medical Education for April 1974. The 1973 figure included students who studied in 17 foreign countries, led by Mexico with 718.

Others were Belgium, 74; Italy, 70; Spain, 35; Philippines, 20; France, 12; Switzerland, 10; Dominican Republic, 6; Hungary, 2; Ireland, 3, and one each from Argentina, Costa Rica, Germany, Greece, Iran, New Guinea and Scotland.

A survey of some 4,000 foreign medical graduates taking the January 1973 examination of the Educational Council for Foreign Medical Graduates showed, however, a majority of the foreign physicians coming from Asian countries. This study by Robert J. Weiss, M.D., and others was reported in the June 20, 1974, issue of the New England Journal of Medicine.

A total of 1,207 came from the Philippines; 791 were graduates of schools in India, Ceylon and Pakistan and 351 came from other Middle and Far East countries. Europe contributed 677, Cuba 254, Mexico 218 and other Central and Southern American countries 341.

In summary, the Association concurs in the need for changes in the present FMG situation and offers recommendations for effecting the necessary changes.

Graduates of Foreign Medical Schools In the United States: A Challenge to Medical Education

*Report of the Task Force on Foreign Medical Graduates
Association of American Medical Colleges*

**Reprinted from
Journal of Medical Education
August 1974**

Background and Introduction

Throughout the history of the United States immigration has contributed towards the overall development of the work force in the country. The medical profession has been no exception. However, the arrival of physicians educated abroad and their integration in the United States systems of medical education and service have reached unusual proportions in recent years. Furthermore, many American college graduates have sought medical education abroad and are now beginning to return home with a medical degree earned in a foreign country. These students add a domestic dimension to problems which stem from the rapidly increasing number of foreign medical graduates (FMGs)* entering the country and being licensed to practice. The complexity of education, accreditation, and licensure in medicine further complicates the situation.

The Phenomenon

The basic trend of admitting FMGs into the United States is represented in Table 1. It shows that in a little over a decade the rate of increase in the number of FMGs in the United States has been four times greater than the rate of increase in the total physician supply. FMGs are approaching 20 percent of all physicians, and one-third of all internship and residency training posts are filled by them. In 1972 more graduates of foreign medical schools entered the United States than physicians were graduated by our own schools, and

46 percent of all newly licensed physicians in that year were FMGs.

The Immigration and Naturalization Act amendments of 1965 have had a major impact on the migration of FMGs to the United States. Termination of the national origins quota system previously in effect opened avenues of entry to the United States for physicians trained in countries where, even in the face of major unmet health needs, the available physician supply appeared to exceed effective economic demand. In addition, preferential immigration status was assigned to professional and occupational skills presumed to be in short supply nationwide, including medicine and other health skills. The result was that physicians from developing countries began to take advantage of the opportunity to immigrate to the United States regardless of their ability to meet licensure requirements in this country.

Foreign-born FMGs are admitted to the United States both as immigrants (permanent residents) and as nonimmigrants (primarily exchange visitors). In the 11 years ending June 1972, over 50,700 physicians entered this country as exchange visitors, the great majority for graduate medical education. During 1967-1970 about 44 percent of all physicians entering the United States have been immigrants and 52 percent exchange visitors. This has begun to change, however. In 1971 and 1972 more physicians were admitted as immigrants (53 and 63 percent respectively) than as exchange visitors. A major portion of these admitted immigrants, however, were FMGs who converted from nonimmigrant status while residing in this country. Legislation in

* For the purpose of this document a foreign medical graduate is a physician who has completed the requirements for graduation from medical school and for practice in a country outside the United States, Canada, and Puerto Rico.

TABLE 1
TEN-YEAR TREND IN ADMISSION, EMPLOYMENT, AND LICENSURE OF FMGs AND GRADUATES OF DOMESTIC MEDICAL SCHOOLS

	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1
ECFMG Data												
Exams Administered	14,535	19,130	18,511	18,337	18,988	19,188	19,548	22,598	29,950	31,033	32,072	37.
Candidates Passed	6,054	6,043	6,820	7,724	7,842	8,770	7,774	8,127	11,916	9,693	12,837	12.
FMGs Certified	*	*	*	*	6,699	5,364	6,142	4,686	5,436	6,886	8,712	6.
Admission to U.S.												*
Exchange Visa	3,970	4,637	4,518	4,160	4,370	5,204	5,701	4,460	5,008	4,784	3,935	4.
Immigrants	1,297	2,093	2,249	2,012	2,552	3,326	3,128	2,756	3,158	5,756	7,143	7.
Total†	5,767	6,730	6,767	6,172	6,922	8,897	9,125	7,515	8,523	10,947	11,416	12.
U.S. Graduates	7,168	7,264	7,336	7,409	7,574	7,743	7,973	8,059	8,367	8,974	9,551	10.
Graduate Medical Education												
Interns: U.S.	6,900	7,136	7,070	7,296	7,309	7,573	7,506	7,194	7,869	8,213	8,120	7.
FMG	1,273	1,669	2,566	2,821	2,361	2,793	2,913	3,270	2,939	3,339	3,946	3.
Total	8,173	8,805	9,636	10,097	9,670	10,366	10,419	10,464	10,808	11,552	12,066	11.
Residents: U.S.	21,914	22,177	22,433	22,852	22,765	22,548	23,116	23,816	25,013	26,495	28,970	30.
FMG	7,723	7,062	7,052	8,153	9,133	9,502	10,627	11,231	12,126	12,968	13,543	14.
Total	29,637	29,239	29,485	31,005	31,898	32,050	33,743	35,047	37,139	39,463	42,512	45.
Licensed to Practice												
U.S. Graduates	6,648	6,832	6,605	7,619	7,217	7,267	7,581	7,671	8,016	7,943	7,815	*
FMGs	1,357	1,451	1,306	1,528	1,634	2,157	2,185	2,307	3,016	4,314	6,661	*
Total	8,005	8,283	7,911	9,147	8,851	9,424	9,766	9,978	11,032	12,257	14,476	*
Physicians in U.S.												
U.S. Graduates	*	245,550	*	*	*	*	*	271,390	276,811	282,609	288,525	*
FMGs	*	30,925	*	*	*	*	*	53,552	57,217	62,214	68,009	*
Total	268,000	276,475	284,224	292,088	303,375	308,630	317,032	324,942	334,028	344,823	356,534	*

* Figures not available.

† Beginning in 1967 the total includes other categories of nonimmigrant physicians.

1970 facilitated this trend by eliminating the requirement that exchange visitors be absent from the United States for a period of two years after ending their studies, provided they were from countries where their special skills are not in short supply.

There is an emerging group of American-born FMGs who seek medical education abroad after failing to gain admission to a medical school in the United States. They request entry into the American medical education system at various stages of their training. Accurate figures regarding these students are not available, but it is estimated that as many as 6,000 students are currently enrolled in medical schools abroad, compared with 50,716 students in American medical schools in September 1973. According to a recent survey carried out by the Division of Manpower Intelligence of the Bureau of Health Resources Development, in 1971-72 medical schools of Latin American universities had 2,045 American students enrolled, 91 percent of whom were at the Universidad Autonoma de Guadalajara in Mexico. In 1970 the AAMC initiated the Coordinated Transfer Application System (COTRANS) which arranges for qualified American students to take Part I of the examination of the National Board of Medical Examiners (NBME) and apply for transfer into a United States medical school. As of May 1973 a total of 442 American students had been admitted through this mechanism to domestic medical schools for advanced standing.

Evaluation of FMGs for Admission

Admission to graduate medical education programs and to state licensure examinations generally is predicated on the fact that the graduate has met the education requirements of an accredited medical school in the United States or Canada.

Before 1955 the Council on Medical Education of the AMA attempted to approximate the system of evaluating medical education in the United States by preparing a list of foreign medical schools considered of sufficient quality for graduates to be admitted into domestic graduate medical education programs. Because this practice proved unsatisfactory, the Educational Council for Foreign Medical Graduates (ECFMG) was established as an independent agency sponsored by the AAMC, the American Hospital Association, the Association of Hospital Medical Educators, the American Medical Association, and the Federation of State Medical Boards to develop a system of certifying minimal educational accomplishments of FMGs. For certification the ECFMG requires proof that the candidate has fulfilled all requirements of a medical school listed in the *World Directory of Medical Schools* (WHO) and the requirements for practice in the country where the school is located, and has received a passing score on an examination furnished by the NBME. The examination is prepared by a test committee from questions provided by the NBME. Eighty percent of the questions are taken from Part II of the NBME examination.

Since its inception in 1958 the ECFMG has organized a worldwide network of 178 examination centers in which a cumulative total of 313,885 examinations has been given to 178,325 candidates. The overall pass rate, including all repeaters, through 1972 is 67 percent. Upon the first try 45 percent obtain a passing score, while a decreasing percentage of those who fail in the first attempt pass in subsequent tries. There is great variation in performance of FMGs from different countries and from different schools within some countries.

Some Characteristics of FMGs

Country of origin—Until recently the majority of FMGs came from European or other countries with standards of medical education similar to those in this country. As a consequence of the amendments to the Immigration and Naturalization Act passed by Congress in 1965, the number of physician immigrants from Asian and other developing countries increased rapidly. As Table 2 shows, 27 and 12 percent of the 2,093 physician immigrants came from Europe and Asia respectively in 1963, while the corresponding figures for 1972 were 13 and 70 percent out of a total 7,143 FMGs. This represents a major shift in nationality of physicians coming to the United States and also in the nature and quality of their medical education because one should not expect medical education offered in developing countries to be the same as that of economically and technically developed nations.

Performance—In objective-type examinations FMGs perform at a lower level than do graduates from American medical schools. Thus, in the past few years the failure rate in the ECFMG examination (score below 75) has varied from 67.4 to 56.9 percent, while students or graduates of American schools have had a failure rate of 14 percent on Part I and 2.5 percent on Part II of the NBME examination. In FLEX (Federation License Examination) 50 percent of FMGs have passed versus 85 percent of gradu-

ates from American schools. In specialty board examinations the failure rate in 1972 was 63 percent for FMGs and 27 percent for domestic graduates. It must be emphasized that there is a much wider spread of performance with FMGs and that some perform as well as domestic graduates. It is generally acknowledged, though not proven, that the medical care rendered by some FMGs is of poorer quality than that rendered by graduates from domestic schools. American FMGs have a similar if not greater failure rate in the ECFMG examination than foreign-born FMGs. This suggests that language difficulties do not significantly influence performance in standardized examinations of this kind.

Specialty and geographic distribution—As shown in Table 3, FMGs are distributed by specialty in much the same way as physicians educated in the United States. They are concentrated largely in the five major specialties and general practice chosen by United States graduates. Approximately 52 percent of FMGs versus 57 percent of graduates from domestic medical schools select internal medicine, pediatrics, general surgery, obstetrics and gynecology, psychiatry, and general practice.

Proportionally more FMGs are in specialties such as anesthesiology and physical medicine, while fewer FMGs are in dermatology and orthopedic surgery. In addition, FMGs are disproportionately found in some residency programs.

TABLE 2

COUNTRY OR REGION OF FMGS EMIGRATING TO UNITED STATES, 1963 AND 1972

Year	Europe		Canada		Latin America*		Asia		Other†		Total No.
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent	
1963	575	27.5	467	22.3	580	27.7	260	12.4	211	10.1	2,093
1972	911	12.7	439	6.4	372	5.1	4,996	69.9	425	5.9	7,143

* Includes South America, Mexico, and Cuba.

† Includes Africa, Oceania, and selected countries of the Americas.

TABLE 3

SELECTED SPECIALTY DISTRIBUTION OF FMGS AND U.S. MEDICAL GRADUATES AS OF 1970

Specialty	All Physicians		Foreign Medical Graduates*		U.S. Medical Graduates	
	No.	Percent	No.	Percent	No.	Percent
Internal Medicine	41,872	12.5	6,894	10.9	34,978	12.9
Pediatrics	17,941	5.4	3,787	6.0	14,154	5.2
General Surgery	29,761	8.9	5,748	9.1	24,013	8.9
Obstetrics-Gynecology	18,876	5.6	3,403	5.4	15,473	5.7
Psychiatry	21,146	6.3	5,588	8.7	15,558	5.8
Subtotal 1	129,596	38.8	25,420	40.1	104,176	38.5
General Practice	57,948	17.3	7,512	11.9	50,436	18.6
Subtotal 2	187,544	56.1	32,932	52.0	154,612	57.1
Other	146,484	43.9	30,459	48.0	116,025	42.9
Total	334,028	100.0	63,391	100.0	270,637	100.0

* Including graduates from Canadian medical schools.

For example, residencies in general practice, physical-medicine, colon and rectal surgery, anesthesiology, and pathology are more than 50 percent filled by FMGs. This may imply in the future a smaller supply of physicians born and educated in the United States for these specialties.

Therefore, in the aggregate FMGs are distributed along the same lines as our own graduates, although for certain specialties there is a differential distribution between FMGs and graduates from domestic medical schools. It remains to be seen whether this differential in enrollment in residency programs will have any impact on specialty distribution in practice at a later time.

The participation of FMGs in the practice of medicine has further distorted the geographic distribution of physician manpower in this country. It has been shown that they follow a similar pattern as that of physicians educated in the United States and tend to concentrate in cities.

State institutions—In many states the demand of public institutions for physicians is accommodated by special licensure provisions for FMGs not fully qualified to practice. The extent to which these FMGs are employed and the impact of their activities on medical care are not

known. However, anecdotal evidence suggests that much health care delivery in the public sector depends on physicians not fully qualified but willing to accept working conditions and income levels qualified physicians will not accept.

Academic medicine—Many FMGs have entered careers in academic medicine in this country. Usually these are physicians who either already have established a reputation in their home country and found the working conditions more attractive in an American institution or have demonstrated unusual capabilities within an American graduate program and entered into an academic career in this country. In 1970 there were 4,291* FMGs in academic positions (including medical education and research) representing 7.5 percent of all FMGs in the United States at that time. This percentage is slightly greater than that of United States medical graduates (about 5 percent). In 1971-72 our medical schools had 4,165 FMGs out of a total of 22,611 salaried physicians on their full-time and part time academic staff. The contribution of FMG scientists to American medical science has been substantial.

* This figure includes U. S. born FMGs.

Dual Standards

The present policy for certifying FMGs has led to a system of dual standards for admission to graduate medical education in this country. To illustrate, Figure 1 gives a graphic representation of the three programs in the continuum of medical education offered in the United States. It shows that the quality of the student's educational experience and performance is ascertained by the following:

1. Accreditation on a national or regional basis of the three required education programs offered consecutively by a

college or university, a medical school, and a teaching hospital.

2. Selection of students for each program on the basis of performance in the previous program or scores obtained in national entrance examinations and broader judgment by a selection committee of the institution.

3. Internal evaluation of the student by the faculty in a continuing fashion and final certification by the faculty for awarding the degree.

4. External evaluation of the student by Parts I and II of the NBME examina-

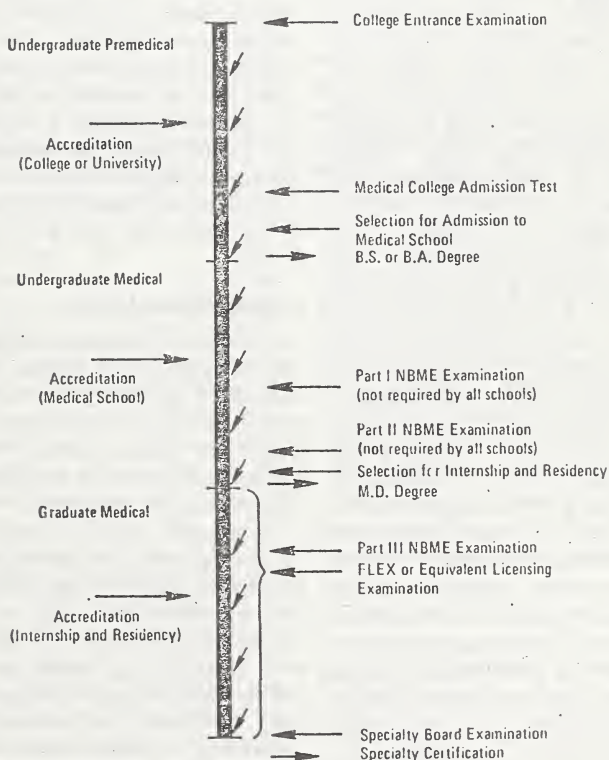


FIGURE 1

Continuum of medical education. The points at which selection and internal and external evaluation of the student occur are indicated at right. Accreditation of the programs is indicated at left. The arrows on the bar indicate internal evaluation.

tion (83 of 116 medical schools require the student to take the NBME examination, while 26 of these schools make a passing score a requirement for promotion or graduation).

5. External evaluation for licensure through FLEX (unless the candidate has already received a passing score on the NBME examination) and for specialty certification by specialty board examination.

The majority of FMGs now applying for admission to graduate medical education has not been screened by equivalent selective internal and external evaluation processes. Furthermore, with notable exceptions, in most countries there is no accreditation system similar to our system. In general, the intensity and quality of the learning experience in the United States are attained by a high faculty student ratio, adequate educational and clinical resources, a competitive situation, and the exposure of the student to the institution's research atmosphere. Finally, by incorporating the student into the medical care programs of the teaching hospital, U.S. medical schools guarantee the American student a participatory role in clinical medicine, while in most schools abroad the clinical student is an onlooker. It may be concluded that while many medical schools abroad are outstanding and excel in many of these same features, the U.S. medical school provides a more intensive learning experience to the student than those institutions from which a large proportion of the FMGs have graduated. Beginning with the extensive premedical education in colleges, the U.S. educational continuum results in a physician-graduate of considerable personal maturity and professional sophistication in the art and science of medicine.

The present mechanism by which FMGs are admitted into graduate medical

education programs implies that the ECFMG examination is a substitute for assessing the quality of the educational process over a period of four to six years and for selecting and evaluating the student for admission and promotion during this period. In reality, there is no examination available for measuring professional competence. Hence, we are faced with dual standards for admission and are condoning the evolution of a dual system of graduate medical education. Currently, a little over one-half of the physicians entering the American system are products of accredited U.S. medical schools, while the balance for the most part represents products of unaccredited education systems. This double standard results in wide disparity in the quality of the physicians admitted to deliver care in the United States. It undermines the process of quality medical education in this country and ultimately poses a threat to the quality of care delivered to the people.

Problems Facing FMGs

The notion that American medical education is rendering a service to foreign doctors by permitting them to enter our system in large numbers must be challenged on several counts. The FMG coming to this country faces difficult and disadvantageous conditions which in many instances offset the potential benefits to be gained from entering the education system. Some of these problem areas are: (a) differences in culture and daily life resulting in isolation; (b) learning of a new language; (c) acceptance into a setting which imposes excessive responsibility for patient care without adequate supervision and educational content; (d) general stigma associated with the status of being an FMG and, therefore, lack of full acceptance on a professional basis; (e) need to accept positions under un-

favorable working conditions and with relatively low salary; (f) acceptance of lower performance level; (g) fear and threat of failure.

The present system of accepting FMGs into the United States and incorporating them into our medical education and care systems has created a category of second-class physicians. From an educational and ethical point of view, this is undesirable.

The Task Force's Response

In reviewing the benefits and problems which accompany the admission of FMGs to the United States, the task force considered many approaches. Although the prohibition of medical practice by FMGs could be considered a possible solution, the long history and ideals of the United States regarding immigration policy make this unacceptable. It was agreed that any recommendations should be in accord with two major considerations, namely that:

1. Medical schools in the United States presently are able to identify outstanding candidates for educational programs which prepare physicians, provide programs of quality medical education to students of medicine, and deliver highly qualified physicians in sufficient numbers into the medical care system of this country. With the rapid increase of enrollment by students in our medical schools (15,000 by September 1975), it is anticipated that our basic need for physicians in the 1980s presumably can be satisfied from domestic sources. If the anticipated number of graduates is insufficient to meet our nationally conceived need for physicians, adequately planned and financed programs should be initiated to increase further the class size of domestic medical schools. It seems inappropriate that the United States with

its existing resources should depend to any significant degree on physicians supplied by education systems of other countries.

2. The dual standards in admission of U.S. and foreign medical graduates must be reduced in the interest of quality of medical education and care as well as for the benefit of foreign graduates who come to this country to achieve medical excellence. Ultimately nobody can gain from the continued existence of two classes of physicians.

The task force is aware of the consequences that corrective measures may have on the number of FMGs gaining admission to graduate medical education in the United States. Because the implications of the present trend are so vast, it recommends that steps be taken to minimize the difference in admission standards between graduates of domestic and foreign medical schools, in spite of the fact that complete equality cannot be achieved rapidly and that some hospitals will be faced with a shortage of house staff during an intermediary period of time. The recommendations do not address themselves to the licensing process except for the loopholes which permit unqualified FMGs institutional medical practice without adequate supervision.

The task force recognizes the similarity between these recommendations and those made by the National Advisory Commission on Health Manpower in 1967 (*Report of the National Advisory Commission on Health Manpower* [Vol. II]. Washington, D.C.: U.S. Government Printing Office, 1967, Pp. 71-81). For their implementation, close collaboration among concerned government and private agencies is required. The task force urges the AAMC to initiate such concerted action.

Recommendations

The task force recommends the following policies to the AAMC for adoption and implementation by the constituency in collaboration with related agencies:

1. *Physician manpower*—Medical schools of the United States must become the major source for educating physicians to satisfy the need for physician services to the American people. This country should not depend for its supply of physicians to any significant extent on the immigration of FMGs or on the training of its own citizens in foreign medical schools. If the anticipated need for physicians exceeds present or future enrollment in our medical schools, appropriate measures including adequate funding must be taken to enlarge the student body accordingly. Since there is a delay of seven to 10 years until a corrective increase in first-year medical school admissions first becomes manifest in terms of physician manpower, a continuing analysis of our physician needs is called for.

2. *Admission criteria*—The process of certifying FMGs for admission to graduate medical education programs in the United States is inequitable and inadequate. In order to apply the same standards to all medical graduates, it is recommended that a generally acceptable qualifying examination be developed as rapidly as possible and be made a universal requirement for admitting all physicians to approved programs of graduate medical education. Until such an examination becomes available, Parts I and II of the NBME examination or the FLEX examination should be required. FMGs can register for these examinations only after having demonstrated an acceptable command of spoken and written English.

3. *Approval of programs of graduate medical education*—In order to ensure all medical graduates of a continuing exposure to quality education, regulations for the approval of programs of graduate medical education must be strictly enforced. The regulations should emphasize the educational function of these programs. In addition, the relative number of FMGs permitted in any program should be limited and geared to the educational resources of the program. Effective adaptation and enculturation cannot be expected unless special efforts are made and there is a balance between American and foreign graduates in the program. Since undergraduate and graduate medical education are considered integral parts of an educational continuum, it is also recommended that the number of first-year positions in approved programs of graduate medical education be adjusted gradually so as to exceed only slightly the expected number of graduates from domestic medical schools and to provide sufficient opportunities to highly qualified FMGs.

4. *Pilot project*—Because examinations to determine the professional competence of the physician are still in a developing stage, it is recommended that a pilot project be initiated for the enrollment of a limited number of FMGs as students in modified undergraduate medical education programs in U.S. institutions. The objectives of this project to be undertaken by the AAMC and interested medical schools are to identify the educational deficiencies of FMGs and provide supervised learning experiences to correct these deficits with the goal of bringing the FMG to a level of professional com-

petence similar to that reached by graduates of domestic schools. In this project preference should be given to U.S. citizens and may include American students enrolled in foreign medical schools qualified for participation in the COTRANS program.

5. *Loopholes*—On the basis of temporary licenses or exemptions from licensure provisions, a large but unknown number of FMGs are delivering medical services in institutional settings such as state institutions and other medical service organizations. They are active in this capacity without having qualified either for graduate medical education or licensure. The indefinite continuation of unsupervised medical practice on this basis without involvement in approved graduate medical education should be discontinued. It is recommended that the AAMC join with the American Hospital Association, the American Medical Association, and other agencies to bring this problem to the attention of the Federation of State Medical Boards in a concerted effort to seek and implement appropriate solutions.

6. *Hospital patient care services*—These recommendations when implemented undoubtedly will reduce the number of FMGs qualified for appointment to positions in graduate medical education. Therefore, new methods must be developed to ensure patient care services in many hospitals. The task force believes that other health care personnel can be trained to provide under physician supervision many of the services now required to be rendered by physicians. Projects to study and demonstrate the engagement of such personnel in institutional care settings should be undertaken immediately. Ultimately, the efficient utilization of such personnel depends on appropriate education of the health care team, particularly physicians, and thus is a conjoint

responsibility of medical and other health profession faculties.

7. *Special categories*—The task force recognizes two categories of FMGs which require special consideration. The first category includes FMGs who are seeking limited educational objectives in this country with the full intent of returning to their home country. They may be accepted into special programs without the qualifications contained in the second recommendation of this report, provided these trainees are not permitted to assume any independent patient care obligations and provided the training thus obtained is not credited towards specialty board qualification in this country.

The second group encompasses FMGs who have established reputations as medical academicians and are appointed by medical schools as visiting scholars. Unless the respective state licensing boards prescribe differently, temporary exemptions from the requirement specified under recommendation two should be accorded these FMGs provided they are visiting members of a medical faculty and their involvement in the practice of medicine is limited to patient care related to their teaching obligations. The granting of these exemptions should be based on a policy agreed upon nationally and should cover a delimited period of time. FMGs who serve on medical faculties as teachers and scientists without patient obligations including supervision of those who render patient care do not fall within the purview of these recommendations.

8. *Timetable*—In establishing a timetable for implementation of these recommendations, considerations must be given to a broad range of consequences, including educational policies of our medical schools, maintenance of undisrupted patient care services within and without teaching hospitals, and cost.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

October 20, 1975

WASHINGTON: 202: 466-5175

Mr. LeRoy Goldman
Staff Director
Senate Health Subcommittee
4228 Dirksen Senate Office
Building
Washington, D.C. 20510

Dear Lee:

At the hearings on foreign medical graduates, Senator Kennedy asked the Association to try to develop some information on the cost of providing educational programs to U.S. citizens attending foreign medical schools to bring their knowledge and skills up to U.S. standards. I have queried a number of medical schools in this country that have participated in the Fifth Pathway Program to get their estimates of costs. The costs obtained from five schools range from \$15,000 per student to \$26,000 per student. Some of these costs are offset by tuition charged to the students.

The costs are made up of faculty salaries, administrative costs, and student subsistence. It is estimated that one faculty member at the Associate Professor level or above is required for the clinical instruction of every three students.

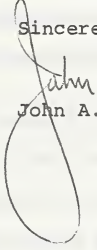
The Legislatures of Illinois, California and New Jersey have passed bills which provide support for Fifth Pathway Students. The following is information on the specifics of the program in each of the three States:

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- Illinois - \$60,000 is granted to each school accepting Fifth Pathway students. The number of students is not specified, i.e., a school will receive \$60,000 regardless of whether it takes one or twenty students.
- California - \$10,000 per candidate is specified in Legislative Assembly Bill #2971.
- New Jersey - \$20,000 per hospital was awarded in 1974 to each of eight participating hospitals taking a total of 75 students. An additional \$47,000 was attributed to administrative costs (\$27,600 per student).

I hope that this information will be of some value to you as you consider the health manpower legislation.

Sincerely,


John A. D. Cooper, M.D.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

Re: Graduates of Foreign Medical Schools

For the Subcommittee on Health

Committee on Labor and Public Welfare
United States Senate

September 26, 1975

Exchange of students of medicine and physicians among nations has taken place for centuries. In the colonial period, many persons entering the study of medicine went to Europe for their study and European physicians came to the colonies to practice medicine. Citizens of the United States continue to go abroad to study medicine and to take special advanced training. Citizens of other nations continue to come to this country for premedical preparation, to attend medical schools and to participate in graduate medical education.

In the early twentieth century and particularly between World War I and World War II medical education in the United States improved greatly, at all levels, the American Medical Association being a major force in this improvement. The number of citizens of the U.S. seeking medical education in medical schools and hospitals outside the U.S. declined steadily during this period. The number of physicians educated outside the United States who came to this country, particularly from Europe, increased rapidly in the mid and late 1930's.

The disruption of education, particularly in Europe, during World War II, the increasing eminence of the United States in biomedical sciences and in medical education, the general economy and social and political climate and the concern of the Congress and others to assist in the rehabilitation of nations whose educational systems had been seriously disrupted by World War II, culminating in the exchange visitor programs for foreign nationals seeking edu-

cation in the United States, have led to a marked increase in the number of foreign national foreign medical graduates who have come to the U.S. particularly for graduate medical education in approved residency programs.

Recent developments and trends, together with the complex problems and issues which now surround the graduates of foreign medical schools, whether they be citizens of foreign nations seeking medical education at various levels with the expectation of returning to their own nations or seeking to become citizens of the United States, or whether they be U.S. citizens who have not been accepted by medical schools in the United States and have therefore gone to medical schools outside the United States and Canada, have been presented in the 1975 report on foreign medical graduates of the Coordinating Council on Medical Education of which the American Medical Association is a sponsor and one of the founding organizations together with the American Board of Medical Specialties, The American Hospital Association, The Association of American Medical Colleges and the Council of Medical Specialty Societies.

The American Medical Association has encouraged and participated in the maintenance and improvement of the quality of medical education in the United States. It has also recognized and assisted in the expansion of enrollments of students in U.S. medical schools. Its participation in programs to accredit medical schools in the United States and Canada has assured the qualifications of those who graduate from accredited medical schools in these two countries.

It has been generally recognized that the educational experience is of the greatest importance in preparing a physician for the practice of medicine. This is true of every level of education through which the student progresses. Not

only is factual knowledge acquired, the student becomes familiar with the culture, the social, economic and political factors which affect both the physician and the patient. An educational experience of high quality forms the background for effective performance through the acquisition of attitudes as well as knowledge and skills. Accreditation of educational institutions is directed at determining the quality of the educational environment in which the student studies. Examinations are useful for determining the level of factual knowledge possessed by an individual but cannot measure how the knowledge may be used in practice. No substitute has been found for daily observation of a student's performance in a particular educational setting. Certification and licensure are therefore based on an evaluation of educational credentials of the candidate and on examinations to measure factual knowledge.

Recognition of the importance of the educational environment in which the student learned led to attempts to evaluate foreign medical schools in a manner analogous to the evaluation of medical schools in the United States and Canada.

With the increase in the number of physicians educated in other nations who came to the United States shortly before and immediately after World War II, the Council on Medical Education of the American Medical Association addressed the problem of determining the educational achievement of foreign physicians and of assessing the educational programs of foreign medical schools and their relative comparability with those in the United States. In 1949 a procedure was developed by the Council on Medical Education for evaluating and classifying foreign medical schools. This was approved by the AMA House of Delegates in June 1949 and committees were appointed to visit medical schools in Europe. Beginning in 1950, the Council on Medical Education of the American Medical Association with the

Association of American Medical Colleges developed and published a list of foreign medical schools whose educational programs, according to the standards which had been developed to evaluate them, were comparable with medical schools in the United States. The list was admittedly incomplete. Between 1950 and 1955 the American Medical Association and the Association of American Medical Colleges continued to publish the list. Problems of completeness, of visits to the schools, of the rapidly increasing number of new schools developing in other nations, the international relations involved, and political factors made it increasingly difficult to assess the foreign schools and to maintain reliable, accurate and complete lists. After five years of major effort, the listing was discontinued.

Because it has not been feasible for agencies in the United States to accredit medical schools outside of the United States and Canada, and because these schools may vary in the content of their educational programs, the assessment of the qualifications of physicians educated in foreign medical schools has necessitated the development of other determinants of the equivalency of the medical knowledge of physicians who have received their medical education in one of many diverse foreign educational programs.

For many years, licensure or completion of an educational program which makes a physician eligible for licensure in the country in which the medical school is located has been considered the end point of education afforded by a foreign medical school. This determination has, with the examination procedures of voluntary agencies, and the requirements of state boards of medical examiners, assured the eligibility of graduates of foreign medical schools to enter the mainstream of medicine in the United States.

The entrance into this country of increasing numbers of graduates of foreign medical schools, particularly citizens of nations other than the U. S. in

late 1940's and early 1950's, their placement in approved residency programs in institutions and hospitals of the United States, and the assurance to the public, to hospital and medical staffs and to directors of residency programs of the readiness of graduates of foreign medical schools to participate in graduate medical education and medical care of patients in the United States became a matter of great concern to the Council on Medical Education and to the House of Delegates of the American Medical Association.

In 1954 the House of Delegates of the American Medical Association on the advice of its Council on Medical Education established the Cooperating Committee on Graduates of Foreign Medical Schools. Its membership included representatives of the Council on Medical Education of the AMA, the Federation of State Medical Boards of the United States, the Association of American Medical Colleges and the American Hospital Association. This Committee was charged with outlining the principles and recommending organizational framework for the evaluation of the medical knowledge and the understanding of English of foreign medical graduates in order to meet the many and varied needs of foreign medical graduates seeking graduate medical education in the United States, to safeguard patients who were in institutions and hospitals offering approved residency programs, and to assure to residency program directors and medical staffs of the readiness and ability of graduates of foreign medical schools to undertake and complete approved residency programs in this country.

In 1955 the Council on Medical Education reported to the House of Delegates of the American Medical Association the principles established by the Cooperating Committee on Graduates of Foreign Medical Schools for appointment of foreign medical graduates to approved residency programs. It was recommended that

appointments be made only when: (1) ability to use English was sufficient not to impair the educational program, the rate of learning by the candidate and communication with patients; (2) the foreign medical graduate met standards of medical knowledge equivalent to those of graduates of U.S. and Canadian medical schools; and, (3) approval had been obtained from appropriate State licensing bodies.

The full report of the Cooperating Committee on Graduates of Foreign Medical Schools was adopted by the House of Delegates of the American Medical Association in June, 1956. The need to protect the public from care given by physicians who lacked medical knowledge and communication in English was to be met by establishing an evaluation service for graduates of foreign medical schools which would (1) develop and administer examinations to determine factual medical knowledge and a useable knowledge of English; (2) examine the credentials presented by the candidate as evidence of his completion of a formal program of medical education; and, (3) would issue a certificate to those candidates who completed the examination successfully and whose credentials of medical education met standards established by the evaluation service.

By December 1956 the agency recommended by the Cooperating Committee on Graduates of Foreign Medical Schools and approved by the House of Delegates of the American Medical Association was created under the sponsorship of the American Medical Association, the American Hospital Association, the Association of American Medical Colleges, and the Federation of State Medical Boards of the United States. It was called the Educational Council for Foreign Medical Graduates and received grants from the Kellogg and Rockefeller Foundations to develop and administer examinations and to devise a method of examining and approving credentials and

certifying successful candidates.

The Educational Council for Foreign Medical Graduates performed its first evaluation and certification of candidates in March 1958 and has continued to function, with the full support of the American Medical Association and the other sponsoring organizations since that time. It has performed an effective and essential function, among several programs which it has conducted, in screening candidates for acceptance into approved residency programs in this country.

Although a major concern with the quality of foreign medical schools has related to the non-citizen who wishes to enter the United States either for additional education, or as an immigrant, some of our citizens have, since the beginnings of our country, attended medical schools in foreign countries. In recent years, an unknown but significant number of our citizens have attended foreign schools because of a disproportion between the number of applicants and the number of places in schools in the United States. This disproportion, in spite of the rapid expansion of opportunities for medical education in the United States, coincides with the recent increase in the number of our citizens in that age group which includes medical students.

Foreign medical schools willing to accept any significant number of citizens of the United States are limited in number. They differ in several respects from the approved U.S. medical schools. In general the foreign schools attended by our citizens have large student bodies and relatively small faculties, and are unable to provide the closely supervised bedside teaching which has come to characterize the high quality of our own system of medical education. Some require successful completion of a didactic four year curriculum followed by one or two years of hospital service and/or social service as an integral part of the educational program.

For many years approved medical schools in the United States have accepted a limited number of students from foreign medical schools as transfers with advanced standing, including U.S. citizens attending foreign schools. This pathway for the return from foreign schools has been facilitated by the Coordinated Transfer System (COTRANS) of the Association of American Medical Colleges. This pathway has obvious advantages not only because it permits an earlier return to study in the United States, but also because the successful student will graduate from an approved school in the United States. COTRANS sponsors participating students as candidates for Part I of the examination of the National Board of Medical Examiners. The collated credentials of successful candidates are made available to medical schools in the United States.

A summary of COTRANS for the years 1950 through 1974 indicates that 3,844 applicants were eligible to take the Part I examination of the National Board of Medical Examiners. Of the 3,150 examined, 1,044 or 33.1% passed and 826 students transferred to medical schools in the United States.

It is also possible for citizens of the United States in the foreign medical schools to complete the entire program of medical education as defined by the foreign country. Those who have evidence of successful completion of the entire program of medical education in the foreign country, and who then pass examinations administered by or acceptable to the Educational Commission for Foreign Medical Graduates receive a certificate issued by this organization. This certificate confers eligibility for appointment to approved programs of graduate medical education on the same basis as graduation from an approved U.S. or Canadian medical school. Many of the state medical boards now require this certificate as a prerequisite for licensure.

The Educational Commission for Foreign Medical Graduates has provided a most important service to graduates of foreign medical schools, to directors of residency programs in the United States, to licensing bodies, to governmental agencies and to the public. It is a separate, non profit organization sponsored by:

The American Board of Medical Specialties
 The American Hospital Association
 The American Medical Association
 The Association of American Medical Colleges
 The Association for Hospital Medical Education
 The Federation of State Medical Boards of the United States
 The National Medical Association

In recognition on fulfillment of their public responsibilities for health care and education, the sponsoring organizations established the Educational Commission for Foreign Medical Graduates. To meet its responsibilities, the ECFMG:

- (1) Provides information to foreign medical graduates regarding entry into graduate medical education and health care systems in the United States;
- (2) Evaluates their qualifications for entry;
- (3) Identifies the cultural and professional needs of graduates of foreign medical schools;
- (4) Assists in the establishment of educational policies and programs to meet these cultural and professional needs;
- (5) Gathers, maintains and disseminates data concerning foreign medical graduates; and,
- (6) Assists, through cooperation and recommendation, other agencies concerned with foreign medical graduates.

Among its important functions is the identification and registration of candidates seeking certification and the identification of physicians holding ECFMG certification for the Department of State, the Department of Labor,

State boards of medical examiners, hospitals and program directors. This service is essential in assuring institutions, organizations and agencies in the United States that candidates have met the requirements for graduate medical education in approved residencies and, where ECFMG certification is a requirement for medical licensure or employment, that individual physicians have met these standards.

Certification by the ECFMG requires that a candidate must have completed at least four credit years (academic years for which he has been given credit toward completion of the medical curriculum) in attendance at a medical school that is listed in the World Directory of Medical Schools published by the World Health Organization.

The candidate must have successfully completed the full medical curriculum prescribed by the medical school or the country in which it is located and must have filled all of the educational requirements to practice medicine in the country in which he has had his medical education. A national of the country must have obtained the appropriate license or certificate of registration.

The candidate must also take and complete successfully an examination given by the ECFMG. This examination is in two parts. The medical part of the examination is a written examination which includes approximately 360 questions of the multiple choice type in English. This examination is prepared by the ECFMG Test Committee working with the National Board of Medical Examiners in the preparation of each examination. The questions are provided by the National Board of Medical Examiners from the large pool of questions which the NEME maintains. Every question used on the ECFMG examination has been used previously in at least one examination of the National Board of Medical Examiners for at

least 5000 students or graduates of medical schools in the United States and Canada. The examination is designed as a comprehensive test of the candidate's knowledge in the principal fields of medicine. Most of the questions are chosen from the fields of internal medicine (including mental diseases and preventive medicine), surgery, obstetrics and gynecology, and pediatrics. The remainder of the questions are chosen from the basic medical sciences of anatomy, biochemistry, microbiology, pathology, pharmacology and physiology.

The second part of the examination is designed to test the ability of the candidate to comprehend and to use English. This part is a modification of the Test of English as a Foreign Language prepared by the Educational Testing Service and is derived from the standard examination used by universities and graduate schools in the United States for applicants from non-English speaking nations. It is required of students entering the educational exchange visitor programs which are conducted under the Fulbright-Hayes Act. The test is 70 minutes in length of which 30 minutes are devoted to oral comprehension. Successful completion of both parts of the examination is required together with documentation of successful completion of the educational requirements outlined earlier for certification of candidates by the Educational Commission for Foreign Medical Graduates.

Through its experience with large numbers of candidates from the many medical schools throughout the world, the ECFMG has gained extensive knowledge of educational requirements and practices in foreign medical schools and licensing requirements of the nations in which the schools are located.

Citizens of the United States studying medicine outside the United States, Puerto Rico or Canada, are considered foreign medical graduates and must meet all

of the requirements that apply to other nationals who graduate from foreign medical schools for certification by the Educational Commission for Foreign Medical Graduates. With the increasing number of students, primarily U.S. citizens, who have received their premedical education in the United States and who go abroad to study medicine, means have been sought to assist them to enter graduate medical education in the United States.

In 1971, the Council on Medical Education of the American Medical Association issued a policy statement to assist students who have completed their premedical education in an accredited American college or university to return at an earlier time from a foreign medical school. Individuals with this academic background who were qualified for but were unable to attend an approved U.S. medical school and who attend a foreign medical school, may return to the United States prior to the completion of clinical or social service requirements by the foreign medical school as part of its curriculum. A year of supervised clinical instruction, sponsored by an approved U.S. medical school compensates for the lack of clinical education provided by the foreign school and obviates remaining in a foreign country for one or two years of hospital and social service activities which may have limited educational value for a U.S. citizen planning to practice in this country. This program has become known as the "Fifth Pathway". As a result of the AMA Council on Medical Education policy statement, those who satisfactorily complete the year of supervised clinical training in conformity with the policy statement are eligible for appointment to approved programs of graduate medical education. The description of this program, revised in 1975, is appended. Twenty-two of the state boards have indicated that those who complete the Fifth Pathway program are eligible, upon completion of other requirements, for examination leading to licensure.

Medical schools are not required to report the number of individuals who satisfactorily complete a Fifth Pathway program, but almost 400 are known to have satisfactorily completed the program in 1972, 1973, 1974, or 1975.

The full implementation of both the COTRANS and the Fifth Pathway programs is limited by the prior commitment of U.S. medical schools to the rapid and major expansion of their student bodies so as to increase the opportunities for our citizens to obtain a medical education in an approved U.S. medical school.

The report of the Coordinating Council on Medical Education on foreign medical graduates contains additional background information and a series of general and specific recommendations which have been accepted by the Coordinating Council and have been referred to each of the parent organizations for consideration. This report is now under active review by the Councils of the American Medical Association which are concerned with medical education and medical service and by the Board of Trustees.

Senator KENNEDY. Our next panel of witnesses will be the Federal Working Group on Foreign Medical Graduates.

We would like to welcome Dr. Harold Margulies, Deputy Administrator, Health Resources Administration, Department of HEW; accompanied by representatives of the Departments of State, Labor, Justice and the Veterans' Administration.

STATEMENT OF HAROLD MARGULIES, M.D., CHAIRMAN OF THE WORKING GROUP ON FOREIGN MEDICAL GRADUATES OF THE INTERAGENCY SUBCOMMITTEE ON INTERNATIONAL EXCHANGES, ACCOMPANIED BY PAUL COOK, PETER LYDON, AND NEIL BOYER, BUREAU OF EDUCATIONAL AND CULTURAL AFFAIRS

Dr. MARGULIES. Thank you, Senator Kennedy.

To reserve your time, I will not introduce all the people who are here at the table. They were members of the reporting group.

I will read my relatively brief statement.

Senator KENNEDY. Fine.

Dr. MARGULIES. I am appearing here at your invitation to present the recommendations of the Working Group on Foreign Medical Graduates. This Working Group was appointed by the Subcommittee on International Exchanges, an interdepartmental body, to represent the Departments of HEW, State, Justice, Labor and the Veterans' Administration. I served as Chairman of the Working Group for DHEW and on June 18, 1975, reported the findings and recommendations of the group directly to John Richardson, Jr., Assistant Secretary for Educational and Cultural Affairs, Department of State, who is Chairman of the Subcommittee on International Exchanges. Because of this arrangement, the report was not first sent for review through the participating departments but is subject to their review. The report is currently being reviewed within DHEW and the other relevant departments. I emphasize that what I report today should not be construed to be the position of any of the participating departments. It was also our responsibility to meet with and obtain the advice of nongovernmental, professional groups concerned with foreign medical graduates. This was done.

To sharpen the focus of our discussions and to avoid some of the issues which we were not in a position to resolve, we agreed to give primary attention to questions of medical education, professional skills, and practice competence of physicians to develop recommendations which we understood should form the basis for Federal policy. It had previously been our experience that the separate responsibilities of the segments of Government we represented tended not to come together when most needed to produce a coherent program.

Further, the role of the Department of Health, Education, and Welfare traditionally has been relatively minor as is indicated in the report.

We agreed that the greatest uncertainty associated with foreign medical graduates as providers of medical care in the United States

was derived from the fact that they had been educated in systems with which we were relatively unacquainted and in institutions which had not been reviewed, modified, and accredited as are the schools of medicine in the United States and Canada. Consequently, we have not been able to depend upon the quality of education as reflected in the accreditation process so well developed in this country. We also agreed that there is no adequate substitute for a full knowledge of institutional quality, that even in the best circumstances the use of an examination as a substitute for broad knowledge of the institution is undesirable but, in this case, necessary.

Based upon that understanding and with full concern for assuring the public that the medical care provided by physicians meets acceptable standards we opted for screening examinations which, as much as possible, measure the cognitive skills expected to be found in graduates of approved medical schools in the United States. The closest we could come to such examinations were the national boards, parts I and II, which have been developed and used on a voluntary basis by medical schools and medical students in this country for many years. You will find that we recommend that these examinations be used for either exchange visitors or immigrants who are expected to be providing clinical services in this country.

The other major aspect of our recommendations has to do with the exchange-visitor program. There was agreement that the purpose of the exchange program, as now defined, is to provide an educational experience in the United States for those who will return to their own countries with new skills for the benefit of the citizens of the country of origin. There is considerable doubt that the skills acquired here are of consistent value in the less-developed countries from which most exchange-visitor physicians come and there is ample evidence that an increasing percentage of exchange-visitor physicians remain here.

In this report we did not examine questions of worldwide migration patterns, economic disparities which attract physicians to richer countries, the rights of the individual versus the rights of the societies which have supported them, or other highly significant but complex issues of great social importance.

We do believe that when this country provides an opportunity for a physician to enter with a visa we have issued because he or she is a physician, the Federal Government has the responsibility to determine as clearly as possible the professional qualifications of the visa applicant or holder. This can better be done within the Government by the Department of Health, Education, and Welfare working in cooperation with the private health sector. Similarly, programs to train people for service in a society strikingly different from our own should be carefully designed for that purpose, kept distinct from training for those educated here who will remain here in medical practice. The working group believes that this also, within the Government, represents a reasonable responsibility for the Department of Health, Education, and Welfare working in close cooperation with the Department of State and the private health sector.

Finally, it was our feeling that the questions of quality of professional services should be examined separately from the questions of total manpower needs so that the concern over the quantity of physicians would not extinguish appropriate attention to quality.

To provide a brief paraphrased summary of the other major recommendations of the report, the following additional comments are made. For those long familiar with foreign medical graduate issues, the executive summary in the report should be adequate but the remaining materials within the report are of high importance for anyone involved in making policy decisions. The United States should meet its health manpower needs through its own resources; in addition to improved medical proficiency screening, there should be improved and more appropriate English language proficiency screening; the exchange-visitor program should not be used as a conduit for physician immigration to the United States; foreign medical graduates should be given the same opportunities and privileges as their U.S.-educated colleagues, discrimination for any reason must not be condoned; there should be regular review of the Labor Department mechanisms for certifying a shortage of physicians in the United States.

Finally, Senator Kennedy, it should be noted that the recommendations of the working group are remarkably similar to recommendations made in a number of reports by public and private groups. There are differences based on procedures rather than on principles, controversy over the relative roles of the Government and private sector, differences over types of examinations, disagreements over manpower estimates and other similar barriers to final resolution. We continue to uphold our principles and follow contrary practices.

The full report of the working group has been submitted to the committee and I hope that you have had an opportunity to review it.

I shall be glad to discuss the report or any other questions you wish to raise.

Senator KENNEDY. Having listened to the CCME comments on it, do you find any areas where you are in substantial disagreement with them?

If so, what are they?

Dr. MARGULIES. I think not in substantial disagreement, but there are real differences which involves the meaning of the national board examination and our purposes for recommending it. We are seeking, as we indicated in the report, to find, as inadequate as it may be, a substitute for our usual knowledge of the kind of medical education received in U.S. institutions which we understand.

As a consequence, we are not looking for something which will allow us to determine whether an individual is ready to practice. We are looking for something which will allow us to understand whether or not his education is equivalent to the education he would receive in this country. And, for that, parts I and II of the national board seem like the most appropriate mechanism.

Senator KENNEDY. How do you react to this point: That the use of the national board examinations will actually discriminate against

FMG's, given the structure of medical education here in the United States and the stress that is put upon the basic science courses. That this, especially part I, really is not a fair test of the medical competency of the person who may have gone to a really outstanding medical institution abroad. That this test is really designed for the American student who has been taking these kinds of courses. So the real qualifications of the person is not really being tested here.

Dr. MARGULIES. Well, I find it difficult to believe that those who would pursue the concept of proficiency examination only would wish to pursue it to the ultimate conclusion that the education which preceded it was of no consequence. It is of great consequences.

We must very carefully separate an effort to find out whether the education, the basic education, was adequate from a measurement of certain kinds of clinical skills which, in a great many instances, can easily be acquired.

Let me give you an example of how confusing this may be.

We did a study some years ago. We asked the administrators of hospitals across the country one question. We did not publish the response because the answer was a little embarrassing.

We said, "In your experience with foreign medical graduates, which are the most proficient by school of origin and which are the least proficient by school of origin?" We wanted to get some impression from them of the very best foreign medical school and the very worst.

One medical school stood out as the very best and one stood out as the very worst. It was the same medical school. All it represented was the degree of experience the administrators had with the individuals.

Measurements of clinical proficiency are notoriously difficult.

Senator KENNEDY. Why is that not as true of the medical schools in this country?

Is it just the accreditation that is stamped on it that resolves this problem?

We will accept a young doctor who graduates from medical school and does not take these exams. By the fact that he has gone to a medical school that is accredited, it is assumed that his medical school education is sufficient, and he can take the State board and practice in that State. Just because you stamp "accreditation," why is he going to be more competent than someone who has gone to a first-rate foreign school? Just because they have not had the same courses in basic science, they may have been outstanding students at first-rate foreign medical schools, but they cannot pass part I?

Dr. MARGULIES. I cannot fully justify with any kind of impeccable evidence that the accreditation process for medical schools in this country is the one upon which we should always depend. I think most of us feel reasonably well satisfied that that is a good process and the very least of medical schools in the United States is excellent.

If you want to move away from that kind of process of assurance of competence, educational process, I think you are on very thin ice.

Senator KENNEDY. I am not suggesting that with regard to the United States.

What I am asking is whether the test to determine medical competence has to be precisely those in part I, which as we know, is very strenuous testing in terms of basic science.

I am open on this.

Dr. MARGULIES. I think one of the reasons we had pushed for part I and II of the national board is to sharpen the discussion around something which is more specific in a broad statement of principle which we have had for the last decade.

Parts I and II are not the only way to do it. They can be done with many modifications. But let us remember that the current ECFMG is a modification of the national board.

What I am concerned with is whether we will end up with a kind of gesture toward proper screening examinations rather than something which is real.

Senator KENNEDY. Are not the national boards the best group to develop this?

Dr. MARGULIES. Yes.

Senator KENNEDY. They have to be given some guidelines in terms of the type of difficulty, I suppose.

Dr. MARGULIES. They are clearly the most competent. I think all of us would not even hesitate about the use of the national board as a resource.

Senator KENNEDY. If you will excuse me, we have a health amendment on the floor. We will include all your statements in the record.

Senator Beall will preside.

Senator BEALL. I am sorry, Doctor, that I missed most of your testimony. But I was presiding in a hearing on pipeline safety downstairs.

Did you talk about waivers?

Dr. MARGULIES. No, sir.

This particular part of the testimony has been confined to the report made by the working group of the Subcommittee on International Exchanges, which is a Federal interdepartmental report. It concentrated on the requirements which we feel would be appropriate for the Federal Government to improve or to try to assure the quality of health services provided by foreign medical graduates regardless of what visa they came in on.

Senator Kennedy had asked me in what ways our report had differed from time preceding one, from the Coordinating Council on Medical Education.

As I said, I felt on all basic principles we were in full agreement. I had answered part of his question.

If I may, Senator, I would like to make one other point for the record which I think represents a difference which this subcommittee would want to hear.

Our recommendations increase the role of the Federal Government, expand the functions of HEW specifically in the whole arrangements for the identification of methods of screening and for the types of education experiences which physicians should have when they come to this country.

I believe that there would be substantial differences between us and the professional societies about whether this Federal function is appropriate and to what extent it should be done.

Senator BEALL. Your report confines itself to the quality of the service to be provided?

Dr. MARGULIES. It confines itself to the questions of foreign medical graduates who are foreign citizens and come in through the visa process.

Senator BEALL. Do you think as we legislate on this subject, we should build in some provision for waiver of whatever requirements we establish in order to serve a need that might exist in a particular area or particular field?

Dr. MARGULIES. Yes; it is almost impossible to write legislation which does not cause some hardships if applied rigidly.

But the waiver process is one of the popular mechanisms for violating the original intent of Congress.

One other thing about the report. Its recommendations, with one exception, represent actions which could be taken as administrative changes and require no further legislation. They are well within existing legislation.

Senator BEALL. You see Congress almost went another route last year, and we want to make sure that the steps we do take, we define what ought to be done in this regard, although it may be some procedures could be carried out administratively.

Dr. MARGULIES. It would help greatly if this committee in regarding the whole issue of health manpower recognized the special role and special problems of foreign medical graduates, and in some way identified the health manpower purposes in its legislation with the appropriate committees of Congress which deal with visas, with labor certifications, et cetera.

I think there needs to be some cross-references, but in those circumstances, it would strengthen the processes greatly.

It is inappropriate and, I think, unwise, to separate the foreign medical graduates from the broad issue of manpower resources needed for this country.

The point we made earlier is that when we get to the issue of quality in our discussions, very frequently the loss of supply alarms people so much that they quickly forget the quality issue. We are not content to let people come into this country who we feel cannot provide good enough care.

Senator BEALL. In our bill last year, we suggested—of course, a person that comes into the country is determined under the immigration laws—but we suggested that if we are going to have foreign medical graduates which come in here, it probably is good to require that at least they meet the same standards that we are imposing on our own domestic graduates, which I do not think you disagree with, and that they speak English.

Dr. MARGULIES. I think generally so.

Senator BEALL. And if they speak English.

Dr. MARGULIES. And speak it well.

Senator BEALL. And so the patient can understand what they are talking about and they can understand the patient.

When you talk about waiver, we did make a provision for waiver of whatever standards, on the assumption that since this is administered by HEW, that they would administer it in good faith.

Dr. MARGULIES. I see no reason to doubt the good faith of HEW.

Senator BEALL. That is why we put it in there. I gather you are objecting to that kind of procedure.

Dr. MARGULIES. No; I am not really objecting.

What I am saying is, the waivers have to be written very cautiously because if you follow the pattern, I am sure some of my colleagues from Immigration Service can expand on this, there is a tendency with a waiver process to find a remarkable number of reasons to do things that are not faithful to the original intent.

I suspect you know better than I do—you are probably subject to pressures from people who want waivers under special circumstances.

Senator BEALL. You can make a comment on the record concerning this, but last year we said that the Attorney General could grant a waiver if, after consultation with the Secretary of HEW, he found that a waiver was necessary to meet the critical needs for which no reasonable alternative exists, and that the alien will be enrolled in a supervised training program designed to identify and correct educational deficiencies of the alien so as to enable the alien to pass the required examinations within a 1-year period.

The waiver may be extended for another year.

Dr. MARGULIES. That created for me at least some very serious problems, particularly as it ran into conflict with State licensure.

I was very doubtful that it would work out well. I do not remember that clearly, and I would be glad to reserve comment later.

Senator BEALL. I would appreciate it if you could give us some comment on this. It would help us this year.

Even if you do not think this should—there should be a waiver provision, maybe you can suggest what changes you would recommend in case there was a waiver position.

Dr. MARGULIES. I would be glad to.

(NOTE: The following statement does not represent the position of the Public Health Service, the Department of Health, Education, and Welfare or the administration; it is the personal view of the witness only.)

As I understand it your primary interest is in the amendments you introduced in the last session of the Congress (S. 3585). I have some problems with the specific requirements introduced in Section 704. First of all, the requirements for Parts I and II of the National Board Examination were not confined to FMGs who would be providing direct patient care. This would mean that it would also restrict those entering for research or administration or other nonclinical duties.

Also, the examination requirement would not apply to physicians coming under family preference categories. Some other arrangement would be needed to cover this number which was approximately 15 percent of total immigrant physicians in FY 73.

Further, the proposed amendment does not apply the examination to exchange visitors who, as a rule, enter the same hospital positions as those who come as immigrants. If the purpose is to provide adequate protection to those who will

become patients of foreign medical graduates the qualifications should be uniform. Incidentally, this raises the same issue for U.S. citizens educated abroad.

One of the biggest areas of misunderstanding appears to be around the definition of physician shortage as required for the issuance of the preference visa and as defined by the Department of Labor. The proposal to identify geographic areas of specific shortage is difficult if not impossible for conceptual and practical reasons. There is no objective evidence that there is any part of the country in which a shortage of certain kinds of physicians—family doctors, anesthesiologists, etc.—does not exist. Further, by Department of Labor standards shortages are defined in accordance with whether or not the immigrant would displace someone already here who could therefore not make a living in his vocation. This also is essentially nonexistent as a physician manpower factor in the U.S. Even more striking is the fact that identification of a geographic area shortage would provide only one mechanism for pointing the way toward entry by FMGs who could immediately relocate and/or change specialty. I know that the labor certification process is being discussed with Labor, but I see no prospect of anyone producing acceptable data which would prove the existence of adequate or excessive numbers of physicians to serve the total health needs of a specific area. The closest we would come to this might be the District of Columbia where the ratio of physicians to population is high but where health services are difficult to obtain in many inner-city areas.

The waiving of requirements to meet areas of critical needs is troublesome. It would assume that the Federal Government would institute and pay for training. It leaves open the questions of when and how FMGs would enroll in training courses during their waivers, whether they or someone else would be required to pay their costs, and how a curriculum would be developed in a very short time. Institutions would have to accept the responsibility for curriculum and teaching at a time when they are unable to accept many eligible U.S. citizens for similar education.

Perhaps most of the worrisome factors with waivers are the problems of licensure and maintenance of location. State Boards would all have to change their requirements and in some cases would have to alter or abandon such examinations as their basic science test. If the foreign medical graduate wanted to relocate he would be exercising his privileges as an immigrant and to restrict him in doing so would be to hold him in a state of bondage as a condition for potential citizenship. If he was unable to meet requirements with training and after examination, he would become a serious responsibility unless he left the country on his own or was deported through the exercise of police powers. Under present circumstances, once an alien is admitted as a permanent resident he is a resident and cannot be deported without just cause: conditional entry for permanent residence does not exist in this country.

Among other things, I am bothered by the inference, which I am sure was not intended, that underserved areas, nearly always areas of poverty often with a high percentage of minorities, can be adequately served by physicians who have not met our requirements and perhaps cannot, but are allowed to practice by setting aside Federal and State professional certification processes. We have had an unhappy experience with the use of unqualified or "less than qualified" physicians in such settings as State mental hospitals. From my personal, professional point of view, I would much prefer the utilization of physician extenders such as nurse clinicians and physician assistants unless and until there is an adequate supply of physicians. Certainly, I could not support a proposal which allows native-born citizens who are all educated at public expense to practice where and how they please, but requires immigrants to live and practice where we say they must as a condition of their acceptance as American citizens.

Senator BEALL. Thank you.

I have no further questions.

Thank you very much.

At this point we will include in the printed record all statements and other pertinent material subsequently supplied for inclusion in the record of this hearing.

[The material referred to follows:]

U.S. DEPARTMENT OF LABOR
OFFICE OF THE SECRETARY
WASHINGTON

OCT 23 1975

Dr. Brian Biles
Staff Member
Subcommittee on Health
Committee on Labor and Public Welfare
United States Senate
Washington, D. C. 20510

Dear Dr. Biles:

During the hearings on Foreign Medical Graduates before the Senate Subcommittee on Health, Committee on Labor and Public Welfare, on September 26, 1975, statements were entered by William D. Holden, M.D., representing the American Board of Medical Specialties, and by Harold Margolies, M.D., of the Department of Health, Education and Welfare, recommending changes in the immigration law and certain administrative changes in the Department of Labor's policies with respect to Foreign Medical Graduates (FMG's).

A representative of the Department of Labor was requested to be present as a member of the Federal Working Group, chaired by Dr. Margolies; however, time constraints prevented him from stating the Department's position on the issues raised concerning our responsibilities, policies and constraints under the present immigration law. We have presented our views before these groups in the recent past, but it appears that some misunderstanding continues. We feel that it is essential to the Subcommittee's goals and efforts that these matters be clarified. We would, therefore, like to present to the Subcommittee a statement to be made part of the record of the Hearing.

Dr. Holden recommended that the government discontinue affording preferential immigration status to members of selected health professions and also discontinue the conversion of temporary visa holders to permanent status. Both of these recommendations, of course, require legislative changes.

The statements of particular interest and concern to us were (1) Dr. Holden's recommendation that "preference or nonpreference immigration visas not be issued on the basis of occupation through blanket (Schedule A) certification by the Department of Labor, and (2) Dr. Margolies' statement paraphrasing the Interagency Working Group's major recommendations that "there should be a regular review of the Labor Department mechanisms for certifying a shortage of physicians in the United States." We feel that framed in this manner, Dr. Margolies' remarks might be misunderstood. The consensus of the Federal Working Group was that removal of FMG's from Schedule A would require processing individual applications which would have to be approved anyway, since data to the contrary are lacking and only result in increased workloads and resulting costs for the Departments of Labor, State, and Justice. Therefore, it was incumbent upon the medical profession groups and HEW to assist the Department by providing sufficient data to support a finding that there is not, in fact, a shortage of physicians by area and specialty.

The Department would like to assure the Committee that we fully support its interest and efforts to meet the U.S. medical manpower needs within national resources, to improve the quality of medical care, and minimize problems related to foreign policy. We have and will continue to participate in efforts to resolve these problems, working with other government agencies and the organizations representing the medical profession.

Section 212(a)(14) of the law states that aliens may not be admitted as immigrants for employment (as opposed to those aliens who qualify for admission based on close family relationship) unless the Secretary of Labor certifies that (1) there are not sufficient qualified, able, willing and available U.S. workers at the time of application, and (2) there will be no adverse effect on the wages and working conditions of resident workers similarly employed.

Numerous court decisions have interpreted this provision to mean that the Labor Department must refer or provide an applicant acceptable to the employer seeking an alien or approve the alien. The problem is further complicated by another provision of the law, Section 203(a)(3). This permits aliens in the professions and those in the sciences and arts who are of exceptional ability to petition in their own behalf - they do not require an employer. Physicians can so qualify and since by the very nature of their work they are primarily entrepreneurs, making determinations on availability of U.S. physicians becomes extremely difficult under existing legislation.

It is generally conceded that there is a nationwide shortage of physicians. The shortage is reflected in Dr. Holden's statement that "There is a need for this country to be self-sufficient in providing the numbers and types of physicians required to meet the health care needs of the Nation" and in the legislation the Subcommittee is considering. On several occasions, DOL has requested data from the medical associations and HEW to demonstrate that there is not a shortage. A necessary part of such a finding would be establishment of criteria to determine how many, by population or by area, by specialty is "sufficient." To date, such data and criteria remain unavailable.

The Department has also made efforts, consistent with the law, to determine what reasonable qualifications the alien FMG's must document in order to qualify. In 1970, after consultation with medical authorities and other government agencies, the following criteria were developed and incorporated into our regulations:

Medicine and Surgery

The application of the art and science of medicine and surgery to the diagnosis, prevention and treatment of diseases and injuries in man, disorders of the mind, and the treatment of women during pregnancy; and research into the causes, transmission, and control of disease and other ailments. Includes the practice of medicine osteopathy, psychiatry, and ophthalmology. May specialize in treating a specific area of the body, or a particular disease, sex, or age group. Provided, That certification under this category shall apply only to those physicians and surgeons whose medical degrees or qualifications were conferred by a medical school in the United States and Canada and such other physicians and surgeons who (a) submit evidence from the licensing authority of the State of the alien's intended employment that the alien has met all of the requirements for licensure or for admittance to the licensure examination in that State; or (b) submit evidence from an institution providing approved medical internship or residency training that the alien has met all of the requirements for appointment to an internship or residency and is being offered such appointment; or (c) submit evidence that they have passed the examination of the Educational Council for Medical Graduates; or (d) submit evidence of having received an appointment to engage in medical teaching, research, or laboratory work that will not involve direct patient care.

During meetings of the Working Group this year, the Department requested that the criteria be submitted to appropriate groups for suggested changes. However, no suggested changes were received.

Therefore, absolutely no purpose would be served by removal of physicians from Schedule A, as Dr. Holden suggests, until sufficient information becomes available to support denials on an area basis. Under the present provisions of the immigration law, to effectively deny or reduce the number of FMG's who could be admitted (or change status) as immigrants for employment would require as a minimum:

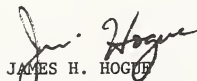
1. Establishment of criteria or standards, by authoritative objective sources supportable in a court of law, which would determine how many physicians by specialty by percent of population or geographic area is sufficient to support that supply-demand is in balance or in surplus.
2. Data on the supply-demand in hospitals, nursing homes and other health institutions which would support a finding of surplus.
3. Standards or tests developed by authoritative source(s) which would be used to determine which FMG's meet U.S. standards.
4. Sources available to DOL regional offices to provide updated data on the above on an ongoing basis.

Modifications to the present law solely with respect to the admission of immigrant alien FMG's will need to consider two factors:

1. Some 25-30 percent of the FMG's entering or converting status each year qualify based on family relationship. They do not require labor certification.
2. Immigrants are free to change employment and place of residence, and prohibitions on such freedom raises constitutional issues. Little purpose would be served in denying the FMG admission to New York City if it were a surplus area, when he/she could then select 4-Corners, New Jersey, if it were a shortage area, and then immediately move to New York City.

We are most appreciative of your agreeing to our request to enter a statement and trust that the foregoing will be of assistance to the Subcommittee.

Sincerely,



JAMES H. HOGUE
Deputy Under Secretary
for Legislative Affairs



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
ROCKVILLE, MARYLAND 20852

OFFICE OF THE ADMINISTRATOR

June 18, 1975

MEMBERS OF THE WORKING GROUP ON FOREIGN MEDICAL GRADUATES

Attached is the material which has been sent as our report to the Subcommittee on International Exchanges. The decision to limit the appended material was consistent with our earlier discussions but was primarily my own judgment about what would serve the interests of the committee members. Other material can be readily supplied on request.

It is my understanding that you will feel free to circulate the report within your Department and to advise on any further comments which may be made from your Department to the SIE. So far as we can tell, the recommendations are consistent with thinking in the Departments represented on the Working Group. No one is committed, however, to the contents of the report to such an extent that additional comments should be resisted.

What I said in my transmittal memorandum is true: the members of the Working Group were excellent individually and collectively bringing into our discussions a combination of knowledge and commitment which was ideal for the difficult assignment we were given. I am deeply grateful and look forward to continued close working relationships

Sincerely yours,

Harold Margulies
Harold Margulies, M.D.
Deputy Administrator

Addressees:

Mr. Charles McCarthy
Mr. John Sheeran
Mr. Paul A. Cook
Mr. Gerald M. Brown
Mr. Peter Lydon
Dr. Arthur S. Cain

Dr. Charles Meyer, Jr.
Ms. Ann Merzel
Dr. Betty A. Lockett
Mr. Raymond Del Rosso
Dr. S. Paul Ehrlich, Jr.

Enclosures



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
ROCKVILLE, MARYLAND 20852

OFFICE OF THE ADMINISTRATOR

JUN 18 1975

Mr. John Richardson, Jr.
Assistant Secretary for Educational
and Cultural Affairs
Department of State
Room 6218
Washington, D.C. 20520

Dear Mr. Richardson:

At the request of the Department of State, the Interagency Subcommittee on International Exchanges appointed a Working Group on Foreign Medical Graduates. The letter setting out the charge to the Working Group is to be found in Addendum F. The full report is transmitted with this memorandum.

The SIE was well aware of the significance of the foreign medical graduate issue and will recognize the importance of the recommendations being transmitted. Members of the Working Group have copies of this report for circulation within their Departments but there was no effort made to carry out individual departmental review prior to this submission of the report to the SIE.

It should be noted that consultation with private health organizations was undertaken. We met with the Coordinating Council on Medical Education in a major conference on this subject, consulted with and reviewed reports from the Association of American Medical Colleges, the National Board of Medical Examiners, and the Educational Commission on Foreign Medical Graduates. The general principles we have outlined are broadly acceptable in and out of Government but you will note differences with the CCME report on specific recommendations.

We have also avoided any detailed analysis of the timing and logistics of proposed changes with the understanding that these factors can be considered when the major decisions involving the recommendations have been made. We recognize that abrupt changes would be undesirable, that the introduction of a new screening examination raises questions of the location of test sites and funding for those examinations. We also recognize that an exchange program which sharply reduces salary

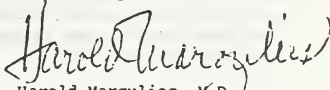
Mr. John Richardson, Jr.

2.

income for FMGs in this country raises other funding problems. We have not dealt with the question of the status of foreign medical graduates who have previously received ECFMG certificates; we have not outlined, for reasons noted above, the impact of recommendations on our domestic manpower supply; and we have not included U.S. citizens who are foreign medical graduates or nurses who have received their training in other countries.

The members of the Working Group were, without exception, well informed, competent, and deeply interested in the subjects under review. They made my work as Chairman relatively easy and gave us all a sense of confidence in the validity of our recommendations. I know that they are ready, as am I, to discuss further with the SIE any or all of the facets of this complex issue.

Sincerely yours,


Harold Margulies, M.D.
Deputy Administrator

Enclosures

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Foreign Medical Graduates and Physician Manpower in the United States

Executive Summary

REPORT OF THE INTERAGENCY WORKING GROUP ON
FOREIGN MEDICAL GRADUATES TO
THE SUBCOMMITTEE ON INTERNATIONAL EXCHANGESPurpose of the Working Group on Foreign Medical Graduates

At the request of the Department of State, the Interagency Subcommittee on International Exchanges (SIE) appointed a Working Group on Foreign Medical Graduates in October 1974. The charge to that Group was:

1. to review all the issues associated with the foreign medical graduates (FMGs) who enter the United States,
2. to consult, as appropriate, within and outside the government for advice on the issue,
3. to explore all areas of concern, and
4. to make recommendations to SIE regarding relevant administrative changes and to propose policies that would represent an overall Federal position.

After the study of numerous background documents and five meetings, the Group fully appreciated the need for timing of the actions it recommends, and the need to coordinate these recommended actions with related proposals from the private sector. The Working Group also became aware of the need to anticipate the interdependence of the various problems related to FMGs and to identify important implications related to each recommendation in the report.

Summary RecommendationsPrinciple I

The national purpose of the U.S. medical education system should be to provide from its own resources a sufficient number of well-trained physicians and other personnel to meet the health needs of the United States.

Principle II

The admission of noncitizen foreign medical graduates to deliver health care in this country places upon the Federal Government a responsibility for determining the adequacy of the foreign educated professional's qualifications. Every effort should be made to provide evidence that those health professionals educated outside the United States are equivalent in professional skills to those educated in our own institutions. Heretofore, the determination of FMG competence has been maintained by the private professional systems with limited comment from Federal agencies. The criteria now in use should be replaced by an improved screening examination which assures those who receive the services of various health care providers that the skills of those providers are acceptable by U.S. established standards. The Federal Government must play a more active role in establishing improved screening.

Principle III

Foreign Medical Graduates who come to this country for graduate training as exchange visitors planning to return to their home countries must be

considered separately from those FMGs who are immigrants to this country; however, under current circumstances both exchange visitors and immigrants are, with few exceptions, providing patient care. All FMGs who enter this country whether as nonimmigrants, immigrants, or U.S. citizens so long as they provide patient care must meet the measure of professional competence referred to in Principle II.

Principle IV

The Educational Exchange Program is for the mutual benefit of the countries of origin of the exchange visitors and the United States, and should not be used to supplement or expand the health manpower resources of the United States.

Principle V

Discrimination against FMGs in the United States is not condoned; they are due the same rights and privileges as U.S. educated physicians at comparable levels of training, experience, licensure, and competence.

The following specific recommendations are made:

That there is no evidence at present for any change in the use of "Schedule A" as a mechanism for facilitating the labor certification process, however, the qualifications required for labor certification have been reviewed by the Department of Health, Education, and Welfare and recommendations for necessary changes in the qualifications requirement follow.

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Addendum C of this report provides the basis for recommending that there be no change in "Schedule A" at this time.

Until such time as a single qualifying examination for entrance into graduate medical education in the United States has been instituted, that the qualifications of a physician for purposes of labor certification for admission to the United States as an immigrant physician be amended as follows: successful performance on National Boards Parts I and II and an English language proficiency test replace the ECFMG examination as a determination that an alien qualify as a physician.

It is recognized that adequate advance provisions must be made for administration of this NBME examination prior to implementation of this recommendation, because administrative problems related to utilization of this examination for the purposes recommended are complex. See Addendum B for a description of those problems.

In addition, in order to be consistent with Principle III and insure that all FMGs who provide patient care meet the same measure of professional competence, it is recommended:

Until such time as a single qualifying examination for entrance into graduate medical education in the United States has been instituted, successful

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performance on National Boards Parts I and II and an English language proficiency test should replace ECFMG certification as a qualification required for all exchange visitor visas and other temporary visas for physicians who will engage in patient care in this country.

This change in requirements for temporary visas will require Immigration and Naturalization Service regulation changes, but will not require new legislation.

Although the Federal role is limited to assuring that the training and qualifications of alien physicians admitted to this country to deliver patient care is equivalent to that of U.S. medical graduates, the Working Group recommends:

That the appropriate professional organizations be urged to require the examination recommended above for U.S. citizen graduates of foreign medical schools who enter U.S. graduate medical education whenever patient care will be delivered.

The following recommendations are made regarding the Exchange Visitor Program that:

The Exchange Visitor Program provides education to the exchange visitor physicians that is directly

related to the needs of the countries of origin.

The period of stay in this country for training be limited to the period required to complete the approved training.

In order to reduce the likelihood of physicians converting from exchange visitor to immigrant status, the exchange visitor physician be required to return to his home country for a period of two years irrespective of source of financing for his exchange program or the present skills list requirements.

The Secretary of the Department of Health, Education, and Welfare in consultation with the Department of State, Veterans Administration, and other appropriate organizations and agencies shall develop guidelines and criteria for administration of the Exchange Visitor Program for the training of foreign physicians. In addition, the Secretary shall approve, monitor, and evaluate training programs for exchange visitor physicians or other nonimmigrant alien physicians.

The Secretary of the Department of Health, Education, and Welfare shall also periodically review the approved programs and make recommendations for either renewal or revocations of authorization of the programs by the Department of State.

REPORT OF THE INTERAGENCY WORKING GROUP ON
FOREIGN MEDICAL GRADUATES TO
THE SUBCOMMITTEE ON INTERNATIONAL EXCHANGES

Characteristics of the Issues

The issues associated with the migration of foreign medical graduates (FMGs)¹ to this country have been considered over a number of years.

Most recently, increased attention has been evidenced in proposed legislation in Congress, in the private health sector, and within the executive branch of the Federal Government. Attached to this summary are documents summarizing specific areas of concern. It should be noted that the Coordinating Council on Medical Education (CCME), which represents the major groups involved with medical education in the United States, has drafted a series of recommendations concerning foreign medical graduates, but that report has not received final approval at this time.

¹ A foreign medical graduate (FMG) is a physician graduating from a medical school outside of the United States (including its Possessions, the District of Columbia and the Commonwealth of Puerto Rico) regardless of the citizenship of the physician.

It should be noted that for credentialing purposes graduates of Canadian schools are not considered to be foreign medical graduates by the medical profession and State Licensure Boards since Canadian medical schools are accredited by the Liaison Committee on Medical Education (LCME) as are United States medical schools.

The following points were of particular importance in the deliberations of the Interagency Working Group.

1. The United States has witnessed an increasing dependence on foreign medical graduates, as evidenced by their percentage of total new additions annually to the medical profession; FMGs are heavily employed in hospitals, but large numbers also are employed in a variety of institutional and private practice settings.

2. There is growing concern about the adequacy of methods which have been employed to determine the professional qualifications of FMGs. In general, there is a realization that (a) we know of no completely valid substitute for a familiar educational process involving graduation from accredited institutions; and (b) the tests which have been used as such substitutes are being increasingly questioned in terms of their adequacy as surrogate measures.

3. The majority of FMGs are coming from less developed countries which have a more pressing need for health services than has the United States. The present migration patterns represent benefits to this country at the expense of the poorest nations of the world--a phenomenon which is causing more and more criticism.

4. The Exchange Visitor Program has not succeeded in training physicians in ways which are most suitable to their country's needs and systems. Even more striking, the Exchange Visitor Program has been utilized as a mechanism for providing domestic professional services in hospitals and is

used as a direct conduit to permanent immigration rather than repatriation as intended.

Specific Categories of Problems

Foreign medical graduate problems have domestic and international implications and each of these broad divisions can be separated into identifiable areas of concern.

1. Domestic Issues

(a) Use of FMGs has decreased the need to expand undergraduate medical education capacities in the United States. At the same time, increasing numbers of qualified U.S. citizen applicants are being denied admission to United States medical schools because of the lack of enrollment capacity. Thus, the United States is not self-sufficient in that it is not producing the number of well-trained physicians and other health personnel required to meet U.S. health needs.

(b) DHEW has a continuing and growing concern with the quality of health services being provided in this country. There is a need to give our institutions and the public more assurance than they now receive that the FMGs are equivalent in professional skills to the graduates of our own accredited medical schools. This question of quality is fully reflected in the present deliberations of professional medical organizations in the United States.

(c) An increasing number of U.S. citizens are going to other countries

for their medical studies and returning as foreign medical graduates. Due to differences in curriculum and educational objectives in various countries, these U.S. citizens face many of the same problems related to the appropriateness and relevance of their medical training as do foreign born FMGs.

(d) DHEW has a continuing need to make accurate projections of the supply of health manpower. Because these projections must include the entry of foreign medical graduates into the health manpower pool (and their departure) it is important that the accuracy and dependability of these projections be protected. There is reason to believe that FMG migration will be increasingly uncertain and there is gross evidence that a sharp reduction in the supply would have a major impact on physician services in the country. FMGs are an unpredictable and uncontrollable source of manpower supply. Thus, to develop a health policy while depending to such a large degree on foreign trained physicians for our health manpower supply is hazardous at best.

2. International Issues

(a) The general phenomenon of the international migration of skilled persons is under study by a number of agencies, including the World Health Organization. The procedures established for the issuance of visas to foreign physicians reflect current legislation and are the direct or indirect responsibility of the Departments of State, Labor, DHEW, and Justice (Immigration and Naturalization Service). Working with the health profession organizations these agencies carry out

their responsibilities as fairly and efficiently as possible. A number of definitions and regulations are required for proper management to this activity and each of these, require updating from time to time. For example, requirements for qualification as a physician must be carefully defined and specified. Furthermore, in order to determine that immigrant physicians and nurses are eligible for labor certification, the Department of Labor must determine whether or not there is a shortage of physicians and nurses in the United States--there is still strong evidence that the shortage persists. On this and other factors summarized in the addenda, any of the agencies may be asked to testify or provide other technical assistance to Congress as it considers amendments to existing legislation or the introduction of new legislation.

(b) The Exchange Visitor Program is of interest to other countries because it represents a potential for obtaining education in the health fields when resources within those countries are too limited. There has not been any review of our vast experience with the majority of exchange visitor activities for physicians, that is, those which confine the education received to clinical hospital settings. There is, however, anecdotal evidence that the type of training received in the United States is not suitable for the countries of origin. Although accurate data are limited on the rate of return of exchange visitors or on their final site of professional activity, there is evidence to suggest that a great many if not most of the exchange visitors do not return home at all.

The United States Government has not set aside funds to support and manage the FMGs Exchange Visitor Program. The rate of exchange has depended upon the usefulness of FMGs as employees in hospitals which can use the FMGs for the provision of medical services. Under this arrangement, approved sites of training for FMGs on a "J" visa are hospitals listed as accredited for internships and residencies, that is, the same as the training offered immigrant FMGs and graduates of U.S. medical schools. The one difference is that the FMGs are more often found in the nonaffiliated hospitals which are known to be more service oriented than are the affiliated hospital training programs.

(c) The Department of State, more than any other Federal agency, receives notice of discontent from countries losing medical graduates to the United States. The familiar argument is that the U.S. can best afford the education of its own and yet depends on the graduates of some of the poorest countries to meet its needs. There has been little or no support for formal proposals from within or outside the United States to restrict the migration of physicians or other highly skilled individuals as a group; but there is a desire for a more effective method of retaining the critical skills of those educated at high expense for the public benefit of the country which has sponsored their training.

Measures of Professional Competence

Unlike other countries the United States has a divided system for measuring the skills of physicians. In most areas of the world,

the right to practice medicine depends entirely upon evidence of graduation from a medical school accredited or otherwise recognized by the country. The United States places its major confidence in the elaborate methods of accreditation of all educational institutions, especially medical schools. The license to practice, however, is issued only by the States or territories; every medical graduate is required either to pass a State examination or the National Board examinations (given in three parts) in which latter case he may be licensed by State endorsement. In recent years, State licensing examinations have become more uniform but are still controlled by individual States. Despite these improvements there is little belief that testing of any kind can measure adequately the totality of the medical education continuum.

Attempts have been made to provide substitute measures of competence for foreign medical graduates who have obtained professional degrees in institutions which we have not accredited and about which we know relatively little. As noted in the addenda the current ECFMG test is derived from selected National Board questions and is designed exclusively for the purpose of determining the capability of an FMG applicant to learn in an approved U.S. internship or residency. There is growing evidence that the ECFMG examination is an unsatisfactory test when it is used to substitute for knowledge of the educational institutions from which the applicants have come.

DHEW currently supports the development of a single qualifying examination for all physicians who are entering hospital training programs where they will have some responsibility for clinical management. This would introduce into the physician training experience a test to determine for U.S. and foreign graduates, alike, suitability for the years of graduate education which are now available without any special testing or additional screening. Because this examination is not yet established and because foreign-trained physicians should be expected to meet the standards of U.S. medical graduates in provision of care in the United States, it is agreed that the most appropriate substitute examination would be part or all of the examination used on a national basis as evidence of physician competence.

After consideration of the issues stated above, the Subcommittee on International Exchanges Working group on Foreign Medical Graduates developed the following general principles and specific recommendations for a coordinated Federal policy in this area:

Principle I

The national purpose of the U.S. medical education system should be to provide from its own resources a sufficient number of well-trained physicians and other personnel to meet the health needs of the United States.

Principle II

The admission of noncitizen foreign medical graduates to deliver health care in this country places upon the Federal Government a responsibility

for determining the adequacy of the foreign educated professional's qualifications. Every effort should be made to provide evidence that those health professionals educated outside the United States are equivalent in professional skills to those educated in our own institutions. Heretofore, the determination of FMG competence has been maintained by the private professional systems with limited comment from Federal agencies. The criteria now in use should be replaced by an improved screening examination which assures those who receive the services of various health care providers that the skills of those providers are acceptable by U.S. established standards. The Federal Government must play a more active role in establishing improved screening.

Principle III

Foreign Medical Graduates who come to this country for graduate training as exchange visitors planning to return to their home countries must be considered separately from those FMGs who are immigrants to this country; however, under current circumstances both exchange visitors and immigrants are, with few exceptions, providing patient care. All FMGs who enter this country whether as nonimmigrants, immigrants, or U.S. citizens so long as they provide patient care must meet the measure of professional competence referred to in Principle II.

Principle IV

The Educational Exchange Program is for the mutual benefit of the countries of origin of the exchange visitors and the United States, and should not be used to supplement or expand the health manpower resources

of the United States.

Principle V

Discrimination against FMGs in the United States is not condoned; they are due the same rights and privileges as U.S. educated physicians at comparable levels of training, experience, licensure, and competence.

The following specific recommendations are made:

That there is no evidence at present for any change in the use of "Schedule A" as a mechanism for facilitating the labor certification process, however, the qualifications required for labor certification have been reviewed by the Department of Health, Education, and Welfare and recommendations for necessary changes in the qualifications requirement follow.

Addendum B of this report provides the basis for recommending that there be no change in "Schedule A" at this time.

Until such time as a single qualifying examination for entrance into graduate medical education in the United States has been instituted, that the qualifications of a physician for purposes of labor certification for admission to the United States as an immigrant physician be amended as follows: successful performance on National Boards

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Parts I and II and an English language proficiency test replace the ECFMG examination as a determination that an alien qualify as a physician.

It is recognized that adequate advance provisions must be made for administration of this NEME examination prior to implementation of this recommendation, because administrative problems related to utilization of this examination for the purposes recommended are complex. See Addendum B for a description of those problems.

In addition, in order to be consistent with Principle III and insure that all FMGs who provide patient care meet the same measure of professional competence, it is recommended:

Until such time as a single qualifying examination for entrance into graduate medical education in the United States has been instituted, successful performance on National Boards Parts I and II and an English language proficiency test should replace ECFMG certification as a qualification required for all exchange visitor visas and other temporary visas for physicians who will engage in patient care in this country.

This change in requirements for temporary visas will require Immigration and Naturalization Service regulation changes, but will not require new legislation.

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Although the Federal role is limited to assuring that the training and qualifications of alien physicians admitted to this country to deliver patient care is equivalent to that of U.S. medical graduates, the Working Group recommends:

That the appropriate professional organizations be urged to require the examination recommended above for U.S. citizen graduates of foreign medical schools who enter U.S. graduate medical education whenever patient care will be delivered.

The following recommendations are made regarding the Exchange Visitor Program that:

The Exchange Visitor Program provides education to the exchange visitor physicians that is directly related to the needs of the countries of origin.

The period of stay in this country for training be limited to the period required to complete the approved training.

In order to reduce the likelihood of physicians converting from exchange visitor to immigrant status, the exchange visitor physician be required to return to his home country for a period of two years irrespective of source of financing for his

exchange program or the present skills list requirements.

The Secretary of the Department of Health, Education, and Welfare in consultation with the Department of State, Veterans Administration, and other appropriate organizations and agencies shall develop guidelines and criteria for the Exchange Visitor Program for the training of foreign physicians. In addition, the Secretary shall approve, monitor, and evaluate training programs for exchange visitor physicians or other nonimmigrant alien physicians. The Secretary of the Department of Health, Education, and Welfare shall also periodically review the approved programs and make recommendations to the Department of State for either renewal or revocation of authorization of the programs.

Health Resources Administration Publications and Projects
Related to the Foreign Medical Graduate Issue

1. Foreign Medical Graduates and Physician Manpower in the United States. DHEW Publication No. (HRA) 74-30, February 1974. Prepared by Betty A. Lockett, Ph.D. and Kathleen N. Williams, M.A., Office of the International Health Manpower Studies, Division of Manpower Intelligence, Bureau of Health Resources Development. This report establishes an information and analysis base to be used in formulating alternative health manpower education strategies.
2. Outline Comparison of Recommendations Related to the Foreign Medical Graduate Issue in Selected Reports and Policy Statements. January 1975. Prepared by the International Studies Staff, Division of Medicine, Bureau of Health Resources Development.
3. Foreign Trained Physicians and American Medicine. DHEW Publication No. (NIH) 73-325, June 1972. Prepared by Rosemary Stevens and Joan Vermeulen, Yale University Medical School, New Haven, Connecticut. A state of the arts monograph on foreign medical graduates in the United States.
4. The Foreign Medical Graduate: A Bibliography. DHEW Publication No. (NIH) 73-440, November 1972. Prepared by the International Studies Staff, Division of Manpower Intelligence, Bureau of Health Manpower Education.
5. Foreign Medical Students in the Americas: 1971-72. DHEW Publication No. (HRA) 74-27. Prepared by the International Studies Staff, Division of Manpower Intelligence, Bureau of Health Resources Development.

This pamphlet reports the results of a pilot survey of the medical schools of the Americas. The purpose of the study was to determine the feasibility of conducting such a survey worldwide in order to improve information on the number of U.S. citizens studying medicine abroad. The survey is now being conducted on a worldwide basis by the United National Educational Scientific and Cultural Organization and preliminary results are available.

6. International Migration of Physicians and Nurses: An Annotated Bibliography. (in press) This bibliography has been developed by the International Studies Staff of the Division of Medicine in collaboration with the World Health Organization (WHO). DHEW is also providing funding for the initial feasibility phase of the WHO study of the international migration of physicians and nurses.

7. 1972 Workshops on FMG Data Base. Two workshops were held in June and October of 1972. The purpose of those meetings was to identify existing data sources and to discuss the possibility of establishing an improved data base on the foreign medical graduates. Participants in those meetings were from other Federal agencies and from the appropriate professional organizations, such as the American Medical Association (AMA), the American Hospital Association (AHA), the Educational Council for Foreign Medical Graduates (ECFMG), and the Commission on Foreign Medical Graduates (CFMG).
8. DHEW Contract No. (NIH) 72-4186. Evaluation of the Existing Data Sources on Foreign Medical Graduates and Survey of Non-ECFMG Certified Foreign Medical Graduates. The final report of this study has not yet been completed for publication, however, several articles including those listed below have been published:

Weiss, Robert J. et al. "Foreign Medical Graduates and the Medical Underground," The New England Journal of Medicine: 290 (25), 1408-1413, June 20, 1974.

Weiss, Robert J. et al. "The Effect of Importing Physicians - Return to a Pre-Flexnerian Standard," The New England Journal of Medicine: 290 (26), 1453-1458, June 27, 1974.

9. DHEW Contract No. 1 PE-44140. A three year demonstration basic science review course for U.S. citizens studying abroad who wish to return to U.S. medical schools to complete their education through the COTRANS program. This is being conducted by the University of Colorado.
10. Contract No. RFC HRA 106 - HSR 225 (4). A study of State policies for issuance of temporary and limited licenses for foreign medical graduates. This is being conducted for DHEW by the University of Michigan.
11. Contract No. HRA 106-74-164. Evaluation of Foreign Medical Graduates and Quality of Care. The Johns Hopkins University. The purposes of this study are: 1. evaluate and compare the performance of foreign medical graduates (FMGs) in the delivery of health care to hospital inpatients by country of medical education and by native language, 2. to evaluate and compare the performance of FMGs in the delivery of health care to U.S. medical graduates by medical specialty. (The Episode of Illness Study Optimal Criteria will be used as the instrument of evaluation for this study.) In addition, the populations served primarily by USMGs and those served primarily by FMGs will be identified by selected characteristics such as: source of payment for medical care, socio-economic status, ethnic background, income level, and geographic location.

SCHEDULE A CLASSIFICATION FOR LABOR CERTIFICATION

Schedule A is an administrative regulation instituted by the Department of Labor (DOL) in order to facilitate the certification process for applications from aliens whose occupations are determined by the Department of Labor to be in short supply nationwide. In the absence of employment statistics and other data to the contrary, the DOL has determined that there is a nationwide shortage of physicians and that the entry of additional aliens who are physicians will not adversely affect wages and working conditions of workers in the United States who are similarly employed. (See Page 3 of this Addendum for a detailed description of Labor Certification.)

At present, under the Schedule A regulation, alien physicians who wish to obtain labor certification must file the necessary forms and documentation with the U.S. Consular Office if he is abroad, or with the Immigration and Naturalization Service (INS) if he is in the United States. If his qualifications meet the requirements he is then "precertified" for labor certification.

If physicians were to be deleted from Schedule A, the forms and documentation submitted would then be forwarded to an area Manpower Administration Office of the Department of Labor where determination of labor certification would be made on the basis of employment statistics in the area designated as the alien's intended residence and other available data.

Removal of physicians from Schedule A would thus greatly increase administrative procedures and staff work involved in the labor certification process.

In the absence of data to the contrary, DOL would continue to issue labor certification to physicians on an individual basis even if physicians were no longer classified on Schedule A. This is due chiefly to the fact that DOL statistics do not indicate significant unemployment of physicians in this country.

Thus, adequate data are required to develop a sound formula which would provide a basis for the DOL to determine specific geographical locations as physician shortage or/surplus areas. The DOL is subject to court action should an alien successfully challenge the determination that labor certification be denied him.

The effectiveness of deleting physicians from Schedule A in an attempt to target FMGs to practice in physician shortage areas cannot be easily determined due to the fact that once admitted as permanent residents these alien physicians would be free to move immediately into another geographical location or occupation.

In the final analysis, the practicality and utility of deletion of physicians from Schedule A would be determined by (1) whether or not DHEW can provide data to support its position that physicians are not in short supply nationwide, but only in short supply in specific geographical locations and within certain specialties; and (2) whether or not it can be anticipated that alien physicians once admitted to the United States with the stated intention of practicing in a given underserved area will remain in that area and not migrate to other non-shortage areas.

LABOR CERTIFICATION

Aliens generally who seek to immigrate to the United States on any basis other than a family relationship to U.S. citizens (or lawful permanent residents), or as refugees, must obtain labor certification as provided in Section 212(a)(14) of the Immigration and Nationality Act as amended. This requirement extends to all special immigrant natives of the Western Hemisphere, all non-preference and third and sixth occupational preference immigrants from the Eastern Hemisphere.¹ Thus, an alien who seeks to immigrate for the purpose of employment, rather than on another basis, is ineligible to receive a visa and is excludable from admission into the United States unless the Department of Labor has determined and certified to the Department of State and to the Immigration and Naturalization Service that "qualified U.S. workers are not available and that his employment will not adversely affect wages and working conditions of the workers in the United States similarly employed."² This certification is referred to as "labor certification".

A schedule occupation classification has been developed by the Department of Labor (DOL) in order to facilitate the labor certification process. There are, at present, two schedules. Schedule A is a classification for occupations that are in short supply nationwide. Schedule B is a list of categories of employment for which labor certification cannot be made. It is composed of low skill occupations for which the learning time is short and little or no education or experience is required. Occupations such as hotel clerks, receptionists, telephone operators, bus boys and taxicab drivers are included. At present, the DOL classifies physicians in "Schedule A", which means that DOL has predetermined that not enough workers in the United States as a whole are able, willing, qualified, and presently available for employment as physicians. On these grounds, the labor certification is deemed granted to the FMG applicant who meets specified qualifications. Successful completion of the ECFMG examination is one such qualification for the Schedule A labor certification. Another is evidence of having met all requirements for licensure or for admittance to the licensure examination in the State of the alien's intended employment. The requirement to obtain labor certification extended to about three-quarters of the FMGs admitted as immigrants in 1972 and 1973.

If it were determined by the Secretary of Labor that physicians are no longer in short supply on a nationwide basis, but only in specific geographic areas, then physicians would be removed from Schedule A. In this instance, each alien physician's application for labor certification would be subject to individual review prior to his being issued an immigration visa and admitted to the United States. Provision of a labor certification would no longer be automatic upon meeting qualifications, but would be determined by the appropriate regional office of DOL. The decision to approve or

disapprove labor certification would then be made on the basis of existing data as to: 1) whether or not sufficient qualified U.S. workers in the area are available and 2) whether or not his employment would adversely affect wages and working conditions of workers in the United States similarly employed. Should that location be designated a shortage area (for physicians), the Labor Department would be responsible for assuring that there are no U.S. citizen physicians willing to relocate and accept employment in that location before it issues labor certification to the alien physicians.

It is necessary for the Labor Department Manpower Administrator to sufficiently document its determination to deny certification since immigrants may take legal action against the Department if certification is denied. In most instances local unemployment statistics and information from other sources such as professional organizations is considered sufficient. It has been suggested that in the case of physicians a sound formula for determination of shortage areas is required and that perhaps DHEW designated shortage areas can be utilized as that formula.

It should also be noted that under the law the terms and conditions of labor certification cannot prevent an immigrant properly admitted to the United States from subsequently changing his occupation, job or area of residence. Thus, once admitted, an immigrant is free to leave the job upon which his labor certificate was obtained almost immediately.

1/ Special immigrants include those who were born in any independent foreign country of the Western Hemisphere or in the Canal Zone and the spouse and children of any such immigrant, if accompanying or following to join him.

Third preference immigrants are those qualified immigrants who are members of the profession, or who because of their exceptional ability in the sciences or the arts will substantially benefit prospectively the national economy, cultural interests, or welfare of the United States.

Sixth preference immigrants are described as qualified immigrants who are capable of performing specified skilled or unskilled labor, not of a temporary or seasonal nature, for which a shortage of employable and willing persons exists in the United States.

Nonpreference immigrants are those other qualified immigrants not included in preferences one through seven, to whom visas may be made available, strictly in the chronological order in which they qualify.

2/ Federal Register, Volume 36, Number 24, Part II, February 4, 1971, Washington, D. C. (29 CFR 60)

Summary Outline

FMGs IMMIGRATION REGULATIONS

Immigrants

I. Numerical Limitations Per Fiscal Year

A. Western Hemisphere: 120,000

B. Eastern Hemisphere: 170,000
(20,000 maximum per country)

Close relatives of U.S. citizens (spouses, children, or parents) are exempt from the numerical limitations regardless of hemisphere of birth

II. Preference Categories (Eastern Hemisphere only)

A. Family Preference

1. First Preference: Unmarried adult sons and daughters of U.S. citizens.
2. Second Preference: Spouses and unmarried sons and daughters of permanent resident aliens.
3. Fourth Preference: Married sons and daughters of U.S. citizens.
4. Fifth Preference: Brothers and sisters of U.S. citizens.

B. Occupational Preferences

1. Third Preference:* Members of the professions and persons of exceptional ability in the sciences or arts. (17,000 visas)
2. Sixth Preference:* Skilled or unskilled workers whose services are needed in the U.S. (17,000 visas)

C. Refugee Preference

(Seventh Preference: Conditional entrants who may acquire permanent resident status after two years.)

D. Non-Preference*

(Visas not used by the seven preferences are made available to persons who are qualified for immigrant visas but who are not eligible for preference)

III. There are no preference categories for Western Hemisphere natives and all Western Hemisphere immigrants are termed "special immigrants"* and enter on a first-come, first-served basis. (Close relatives [children, spouses, and parents of U.S. citizens] are exempt from numerical limitations and labor certification.)

* Labor Certification is required for these immigrant categories.

Immigrants are classified by occupation:

Schedule A - Occupations in short supply nationwide.

Schedule B - Occupations for which certification cannot be made - not needed in U.S.

Non-schedule - Individual certification required.

Nonimmigrants

This group includes diplomats, visitors for business or pleasure, students, temporary workers or trainees, exchange visitors and others. There is no numerical limitations on these persons coming to the U.S. for temporary periods. Most FMGs who enter the U.S. as non-immigrants are Exchange Visitors, and enter under the special J Visa category. Since 1967, about 44 percent of all physicians entering the United States were immigrants, and 52 percent were exchange visitors. This has begun to change, however. In FY 1971 and 1972, of all physicians entering the country, more physicians were admitted as immigrants (58 percent) than as exchange visitors (39 percent). Many FMGs who enter as exchange visitors later change their status to that of immigrant.

ADDENDUM C

Administrative Considerations Related to the Substitution of NBME Parts I and II for the ECFMG Examination as an Immigration Regulation

There are special problems related to the logistics of administering the NBME examination which must be considered if it is to be a replacement for the ECFMG examination as a requirement in the existing Immigration and Naturalization Service (INS) regulations.

At present, the Immigration and Naturalization Act and the Labor Department regulations require that alien physicians seeking permanent immigrant status in the United States under all preference and non-preference immigration categories except for the family preference categories (I, II, IV, V) and refugee category (VII) must either:

1. Have a medical degree from the U.S. or Canadian school or,
2. Submit evidence from the licensing authority of the State of the alien's intended employment that the alien has met all the requirements for licensure or for admittance to the licensure examination of that State or,
3. Submit evidence from an institution providing approved internship and residency training that the alien has met all the requirements for appointment as an intern or resident or,
4. Submit evidence that the alien has passed the ECFMG examination or,
5. Demonstrate that the alien has received an appointment to engage in medical teaching, research, or laboratory work not involving direct patient care.

The requirement of National Boards Parts I and II could be substituted for requirement 4 or 3 and 4. If this is done there are problems related to implementation which was considered by the Working Group. The following potential problems were discussed by the Working Group.

- I. The ECFMG is a one day examination which limits the number of basic science questions. It is given in over 170 centers throughout the world. To take both NBME Parts I and II would require four days of examination in the basic medical and clinical sciences. Students in the United States sit for Part I of the examination after completion of their basic science course work. Thus, in order to provide FMCs with the same opportunity (to take the examination immediately after completion of course work) it would be necessary to administer the NBME examination in two parts.

- II. At present, a candidate for the NBME examination must be sponsored by an appropriate institution approved by NBME. For example, U.S. citizen foreign medical students must be sponsored by the AAMC through the Cotrans Program in order to sit for National Boards Part I. Foreign born FMGs would also require sponsorship under present NBME regulations.
- III. The visa issuance "time-lag" must be given consideration. As indicated in the attached State Department document, as of October 19, 1974, qualified applicants for immigrant visas from the Western Hemisphere countries who had priority dates earlier than June 8, 1972 were being issued visas. This means that presently there is a lag or waiting period of 28 months. For immigrants who apply under the third preference category from the Philippines that waiting period is more than three years. Visas are unavailable in all other categories except family preference. Thus, once an alien from those areas has been determined to be qualified and given a visa number the "time-lag" between the time he is determined to be qualified and the time he is actually admitted may be as long as or even longer than three years.

Thus, some provision will probably have to be made for "pipe-line" cases, that is, those immigrants who qualified under the earlier regulations who have already been granted a visa number and who are waiting for admission.

- IV. The requirement of NBME Parts I and II will almost certainly result in a reduction of the proportion of immigrant FMGs who qualify for entry into the United States. Analysis of the relative difficulty of the FLEX examination Parts I and II (which was developed from the NBME Parts I and II) as compared to the ECFMG examination (the existing examination requirement) gives some indication of the lower pass rate to be expected because the NBME is a much more stringent test than is the ECFMG. According to NBME analysis of the FLEX examination data, approximately 22% of those FMGs taking the FLEX examination would pass the Part I (day one) portion of the FLEX examination without the weighting formula in the scoring of the FLEX examination. Approximately the same percentage of FMGs would pass if the scoring were based on a requirement of passing both the Parts I (day one) and Parts II (day two) portions without a weighting formula. It should be noted that this is a highly selected sample of FMGs as they have already passed the ECFMG and have had training in the U.S. The implication of this higher failure rate must be considered in the development of future health manpower strategies by DHEW.



C - 3

U.S. DEPARTMENT OF STATE

BUREAU OF SECURITY AND CONSULAR AFFAIRS

VISA OFFICE

WASHINGTON D.C.

 Number 81
 VOLUME II

AIR PRIORITY

AVAILABILITY OF IMMIGRANT VISA NUMBERS FOR OCTOBER 1974

1. This bulletin relates to the allocation of immigrant visa numbers for use during October. Consular officers are required to report to the Department of State the priority dates of all documentarily qualified visa applicants each month. The Immigration Service similarly reports the dates of all qualified applicants for adjustment of status. To the extent possible under the numerical limitations, allocations are made for all such demand for visa numbers received by September 10th in the chronological order of the priority dates reported. If there is more demand than can be satisfied within the statutory or regulatory limits, the classification or foreign state or dependent area in which demand is excessive is deemed to be oversubscribed. The cut-off date for an oversubscribed category is the priority date of the first applicant who could not be reached within the statutory or regulatory limits. Only applicants who have a priority date earlier than that date may be issued visas.

2. Allocations of visa numbers for persons born in areas other than the independent countries of the Western Hemisphere are governed by the provisions of Section 203(a) of the Immigration and Nationality Act, as amended, which prescribes preference categories as follows:

- First preference (unmarried sons and daughters of U.S. citizens): 20% of the over-all limitation of 170,000 in any fiscal year;
- Second preference (spouses and unmarried sons and daughters of aliens lawfully admitted for permanent residence): 20% of the over-all limitation, plus any numbers not required for first preference;
- Third preference (members of the professions or persons of exceptional ability in the sciences and arts): 10% of the over-all limitation;
- Fourth preference (married sons and daughters of U.S. citizens): 10% of the over-all limitation, plus any numbers not required by the first three preference categories;
- Fifth preference (brothers and sisters of U.S. citizens): 24% of the over-all limitation, plus any numbers not required by the first four preference categories;
- Sixth preference (skilled and unskilled workers in short supply): 10% of the over-all limitation;
- Seventh preference (refugees): 6% of the over-all limitation;
- Nonpreference (other immigrants): numbers not used by the seven preference categories.

3. A prerequisite for nonpreference classification is a labor certification under Section 212(a)(14) or satisfactory evidence that the provisions of that section do not apply to the alien's case. Since all beneficiaries of approved third and sixth preference petitions are required to have a labor certification in support of the preference petition, such applicants are thereby entitled also to nonpreference classification. Therefore, if visa numbers are not available for them within their preference classes and if nonpreference visa numbers are available for their foreign state or dependent area, they may apply for nonpreference visas. A nonpreference priority date, once established, is retained by the alien even though he may meet the provisions of Section 212(a)(14) at the time of formal visa application by some means other than that by which he originally established that date.

4. Allocations of visa numbers for persons born in independent countries of the Western Hemisphere are subject to the 120,000 annual limitation prescribed in Section 21(e) of the Act of October 3, 1965. There are no preference classes nor foreign state limitations prescribed for applicants born in countries subject to this provision. A Western Hemisphere priority date, once established, is retained by the alien even though he meets the provisions of Section 212(a)(14) at the time of formal visa application by some means other than that by which he originally established that date.

The spouse or child of an immigrant described in any of the categories listed above may be granted the same status as the spouse or parent he is accompanying or following to join.

5. Under the provisions of Section 203(b) of the Immigration and Nationality Act, numbers for applicants born in areas other than independent countries of the Western Hemisphere must be made available in the order of the preference classes. Moreover, within such classes, under Section 203(c) of the Act, they must be made available in the order of the filing dates of the petitions according preference status. In certain foreign states and dependent areas, the demand in the higher preferences exceeds the foreign state and dependent area limitations of 20,000 and 200 per annum, respectively. In these areas, numbers are not available for applicants in the lower preferences or the nonpreference class until demand in the higher preference has been satisfied.

6. A date listed under any category indicates that the category is oversubscribed. (See paragraph 1.) As allocations for following months will be based on reports of applicants who have subsequently become documentarily qualified, it is not possible to predict whether these dates will change appreciably in the near future. "C" means current, i.e., that numbers were available for all qualified applicants under the category so noted at the time the allocations were made. "U" means unavailable, i.e., that no numbers were available for applicants under the category so noted.

FOREIGN STATE ALL FOREIGN STATES IN EASTERN HEMI- SPHERE AND THEIR DEPENDENT AREAS EXCEPT THOSE LISTED BELOW	PREFERENCE							NONPREF- ERENCE
	1ST	2ND	3RD	4TH	5TH	6TH	7th	
	C	C	12-1-73	C	C	C	C	5-1-74
KOREA	C	C	12-1-73	C	C	C	C	6-1-73
PHILIPPINES	C	C	12-8-69	U	U	U	U	U
ANTIGUA	C	6-1-74	U	U	U	U	U	U
BELIZE	C	8-15-73	U	U	U	U	U	U
BRITISH VIRGIN IS.	C	C	12-1-73	C	10-15-72	U	U	U
DOMINICA	C	C	12-1-73	C	9-1-73	U	U	U
HONG KONG	C	6-15-72	U	U	U	U	U	U
MONTserrat	C	C	12-1-73	C	C	1-1-73	U	U
ST. CHRISTOPHER	C	5-15-73	U	U	U	U	U	U
ST. LUCIA	C	C	12-1-73	U	U	U	U	U
ST. VINCENT	C	C	12-1-73	U	U	U	U	U
ANTILLES, NETH.	C	C	12-1-73	C	C	3-1-73	U	U
CAPE VERDE	C	C	12-1-73	10-15-73	U	U	U	U

Numbers allocated for October issuance under the Western Hemisphere limitation were for applicants with priority dates earlier than June 8, 1972.

SCA/VO- September 10, 1974

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Meeting Dates of the
Subcommittee on International Exchanges (SIE)
Working Group on Foreign Medical Graduates (FMGs)

First Meeting November 20, 1975

Second Meeting January 21, 1975

Third Meeting February 25, 1975

Fourth Meeting March 26, 1975

Fifth Meeting May 7, 1975



DEPARTMENT OF STATE

Washington, D.C. 20520

ADDEMDUM F

Mr. David Hohman
Deputy Director
Office of International Affairs
Management
Health, Education and Welfare
Washington, D.C. 20201

August 14, 1974

Dear Mr. Hohman:

Assistant Secretary Richardson has asked that I write to you to say he was delighted to learn at the August 4, 1974 meeting of the Subcommittee on International Exchanges that HEW has agreed to chair an SIE Working Group on Foreign Medical Graduates (FMG's).

The purpose of the Working Group will be to conduct discussions which will clarify the responsibilities, problems and current policies of the various U.S. Government agencies concerned with FMG's. Based on its findings, Mr. Richardson hopes that the Working Group will make recommendations for an overall Government policy on FMG's and submit suggestions for both interagency and public/private cooperation.

The membership of the Working Group would appropriately include, in addition to HEW, the Department of State (Bureau of Educational and Cultural Affairs and Visa Office), Department of Labor, Veterans Administration, and Immigration and Naturalization Service. Since each agency has a different responsibility and perspective, it would be well we believe for the Working Group to include in its deliberations the three distinct but interrelated categories of FMG's: those with immigrant status, those on "H" and "J" visas, and U.S. graduates of foreign medical schools.

On behalf of the Subcommittee, Mr. Richardson thanks you for taking the lead in this very important matter and looks forward to receiving your report.

Sincerely,

William K. Hitchcock
Acting Assistant Secretary for
Educational and Cultural Affairs

FOREIGN MEDICAL GRADUATES AND PHYSICIAN MANPOWER IN THE UNITED STATES

DHEW Publication No. (HRA) 74-30

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service • Health Resources Administration

Bureau of Health Resources Development
Division of Manpower Intelligence
Office of International Health Manpower Studies
February 1974

 PREFACE

Early in 1972, the Division of Manpower Intelligence (DMI), now part of the Bureau of Health Resources Development, Health Resources Administration (BHRD/HRA), was asked to assume responsibility for developing an information and analysis base to be used in formulating alternative health manpower education strategies. This effort, termed Project SOAR (Supply, Output, and Requirements), has three functions: (1) development of new and improved data on current health manpower supply; (2) provision of health manpower supply and requirement forecasts; and (3) identification and assessment of possible Federal Government actions in the health manpower production system that might be needed to alter supply to meet forecasted requirement ranges.

The purpose of this Report, as part of that effort, was to provide data and analyses on the foreign medical graduate (FMG) component of physician supply in the United States and to identify and assess possible Federal Government action options in the area of foreign medical graduates. It provides an initial opportunity to address the multiple implications of FMGs in the U.S. health care system and articulates action alternatives with respect to the immigration, training, evaluation, assimilation, and/or emigration of FMGs. (An earlier version of this report carried the designation BHRD/DMI/OIHMS Report No. 74-47.)

Aside from an introductory chapter, the Report comprises two main sections and two appendices. Chapter II reviews the current situation in the United States with respect to the immigration, education and training, licensing, and practice characteristics of FMGs, together with some illustrative information on U.S. medical graduates. Available data presented on FMGs include country of origin, types of visas, age, sex, major professional activity, specialty, and geographic location.

Separate sections focus on U.S.-born FMGs and FMGs in graduate medical education. Performance is discussed with respect to examinations, licensure, specialty board certification, and more subjective evaluations. Finally, topics in need of further research and analysis are identified. Sections of this chapter draw on a 1972 publication from the Office of International Health Manpower Studies (OIHMS) entitled *Foreign Trained Physicians and American Medicine* by Rosemary Stevens and Joan Vermeulen.

Chapter III focuses on national policy options vis-a-vis FMGs as they are related to quality, accessibility, and cost of care. Action alternatives are outlined as they relate to these elements of the national health care goal ("access to quality medical care for all Americans at a reasonable cost") and, insofar as possible, the positive and negative sides to each alternative are noted. Appendix A presents a flow chart illustrating the avenues by which FMGs enter the United States, obtain graduate training, and take up other professional activities for a medical career. Appendix B, a discussion of the concept of externality and its relationship to interstate and international migration of physicians, was prepared by Dr. Jesse Hixson, then a member of the DMI staff, but currently with the Social Security Administration, DHEW.

This DHEW Publication No. (HRA) 74-30 was prepared by Betty A. Lockett, Ph.D., Chief of the Office of the International Health Manpower Studies, and Kathleen N. Williams, M.A., of the staff.



William A. Lybrand, Ph.D.
Director,
Division of Manpower Intelligence

February 1974

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Graduates; and Dr. Paul Kimmel. Particular appreciation is owed to Dr. John Freymann, Director of Education, Hartford Hospital.

The following persons within the Federal Government also reviewed the draft report: Dr. Thomas D. Dublin, Dr. Peter Eichman, and Dr. William A. Lybrand, Bureau of Health Resources Development; Dr. Milton Levine, National Institute of Mental Health; Mr. Maurice F. X. Donohue, Department of Labor; and Mr. Sam Bernsen, Immigration and Naturalization Service. Final responsibility for omissions or errors of fact or interpretation rests with the Division of Manpower Intelligence.

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FOREIGN MEDICAL GRADUATES AND
HEALTH CARE ISSUES:
An Overview

U.S. HEALTH CARE GOALS AND ISSUES

National debate about the status of health care in America today has engaged three groups — government, professionals, and consumers, each of which has sometimes complementary, sometimes conflicting goals. The overriding and binding goal, however, has been put forth as “access to quality medical care for all Americans at a reasonable cost.” Progress toward that goal, within the Federal Government, has taken the form of a national health strategy which would follow four avenues: build upon existing elements; provide equal access to health care without regard for racial, economic, social, or geographical barriers; balance supply and demand in terms of manpower and facilities; and organize the health care system more efficiently to enable it to meet increased demands of the future.

The health care issues around which the national debate tends to center involve three factors: quality, accessibility, and cost. The quality issue has at least two facets: maintaining the traditional high standards of care, research, and education which are the hallmark of American medicine, and ensuring that the same levels of quality apply to all citizens equally. Similarly, the question of accessibility has several aspects as well: providing a professionally acceptable level of health care services and resources to the entire citizenry with a minimum of travel and waiting time, and establishing and maintaining a health manpower pool of sufficient size and appropriate training to meet increasing demands for primary, secondary, and tertiary health care in all specialties and in a variety of private and public settings. Finally, the matter of costs has two features: finding a means of containing spiraling costs of health

care (especially, for example, hospital costs) and developing innovative ways of financing health care and health professions education so that no one group is priced out of the health care market or shoulders an unfair portion of expenditures for care or education.

Health care being a singularly labor-intensive endeavor, manpower clearly is the central factor with which policymakers, professionals, and consumers alike must deal. The multitude of solutions proposed to address some of the problems inherent in the quality/access/cost issues all reflect, to one degree or another, the understanding that new forms of organizing and financing health care must first and foremost be concerned with the manpower component.

The more all-encompassing actions initiated on a national basis to further the basic goal include proposals designed to expand health maintenance organizations, to extend health planning at all levels, and to advance research and prevention programs in specific categorical areas. Proposals targeted more specifically on health manpower have also been formulated, including legislation for training health manpower and establishing a National Health Service Corps to bring services to rural and inner city areas. Outside the Federal Government, some progress can be discerned in past expansion of the domestic output of medical and other graduates and in the analysis of functions and task delegation within the entire health care system. These steps, significant as they are and have been, have not been sufficient to provide the basic level of health care services implied in the goal stated at the outset.

THE NEED FOR PHYSICIAN MANPOWER

As a consequence of the foregoing, an additional response to the health needs of America has developed — namely, the recruitment and utilization of foreign manpower, in particular foreign-trained physicians. That part of the felt need for physicians in the United States which has not been met through our own resources has been partially filled by doctors drawn from other nations, until the foreign medical graduate component of the U.S. physician manpower pool has become quite

substantial and visible. Foreign medical graduates (FMGs) have entered the United States in increasing numbers in recent years and are now an important component of physician supply in this country (1). The following statistics are illustrative.

Approximately one of every five physicians in the United States was an FMG in 1970. In 1971, over 68,000 foreign medical graduates (active and inactive)

were included in the American Medical Association (AMA) registry of physicians in the United States. It is known that a large number of FMGs in the United States, estimated at 10,000 or more, are not included on the AMA registry. Over one-third of all interns, residents, and other physician trainees in U.S. hospitals approved for such training are FMGs. FMGs (excluding Canadians) accounted for 46 percent of new licentiate additions to the medical profession in 1972. Between 1950 and 1970, the ratio of all active physicians to population increased from 141 per 100,000 to 154 per 100,000. Without the influx of FMGs during that period, the ratio of active physicians to population would have been virtually the same in 1970 as it was in 1950, assuming no other changes in health manpower production had occurred.

The potential size of the annual influx of FMGs into the health care system is capable of matching the output of U.S. medical schools. For example, in the ten years from 1964 to 1973, the annual number of FMGs admitted to the United States (as immigrants or exchange visitors) went from 6,767 to 11,732. U.S. graduates went from 7,336 to 10,391 in the same period.

Many factors currently drawing FMGs to the United States seem likely to continue. The economic incentive is strong; the average residency salary is higher than the fully licensed physician's annual income in many countries of the world. The number of salaried positions in the U.S. market has been increasing. The opportunities for graduate medical education and for satisfying, rewarding practice in those countries from which the largest proportion of FMGs are emigrating are not likely to be enhanced appreciably for many years to come.

Should the United States health care system continue to utilize FMGs in significant numbers? This is a complex question with political and economic implications which include, and go beyond, the health care problems faced by this Nation.

Political Implications

Internationally, the increased flow of foreign medical graduates to the United States has some clearly negative implications. Physician migration from developing countries to the United States has been mentioned as a major element in the criticism directed toward this Nation for its role in the "brain drain" phenomenon. The United States is vulnerable to the charge that it indirectly contributes to poor accessibility of health care in the developing nations.

The total number of physicians involved in international migration has been estimated to be on the order of 100,000 annually (2). The magnitude of the flow is so compelling that member nations attending the 25th World Health Assembly in 1972 requested the Director-General of the World Health Organization (WHO) to intensify the preparation and implementation of a worldwide study of the migration process of physicians and nurses, and its implications for health care in all regions of the world, particularly developing countries (3). Initiation of this study by WHO follows studies and reports sponsored by Unesco and the United Nations Institute for Training and Research (UNITAR) (4, 5, 6). These increasing pressures to study the phenomenon of health professionals migrating from developing to developed countries foreshadow the possibility of diplomatic or economic repercussions by some countries against the United States if there is a continued or increasing flow of their physicians to this country.

Some experts in the developing countries, however, stress the point that unilateral steps to curtail or stop migration of physicians and other health personnel would not, in the long run, be in the best interests of either their countries or our own. For example, a report from the 1970 international conference on the migration of medical manpower sponsored by the Josiah Macy, Jr., Foundation stated that although continued and significant losses of medical manpower from the developing to the developed nations should receive urgent study, "it is important that governmental or statutory restrictions should not be applied to the international movement of doctors" (7). These experts are aware of the long-term direct and indirect values of education and training in the U.S. medical care system.

Certain other political implications related to the issue of the increasing utilization of FMGs are more domestic than international in nature. The number of American college graduates applying to American medical schools has been increasing steadily. Applicants to American medical schools numbered 25,000 in 1970, almost 29,200 in 1971, and over 36,000 in 1972; there are about 40,000 for the current year. To accommodate these applicants, there are at present approximately 13,790 first year places (8). The net effect is that while some U.S. applicants are necessarily turned away from the medical schools because of a lack of space, Americans find themselves dealing more frequently with foreign physicians, especially in hospitals. The question arises as to why funds cannot be allocated so that more U.S. citizens could be trained to fill these positions. Thus, Federal aid to programs which would improve graduate educational employment opportunities for

foreign nationals, while U.S. citizens are denied the opportunity of an undergraduate medical education, will undoubtedly engender resentment.

Economic Implications

The current utilization of medical education and health care delivery resources within the United States has been profoundly influenced by the long-term influx of FMGs. In many places, the structure and operation of the system has accommodated the increasing numbers of FMGs who seek graduate medical education in this country as well as those who wish to remain after completing their training. The impact of policies serving to reduce the rate of influx of FMGs will be most apparent in these areas.

The most controversial impact of FMGs has been in those areas where they are said to be disproportionately represented in the domestic delivery system. These are, *first*, in hospitals where house staff are relied upon to provide patient care services; *second*, in public institutions whose demands for physician manpower have been accommodated by special licensure provisions. In these two sectors of the system — where FMGs are engaged directly in delivery of services — the economic impact of the FMG influx is most apparent. In a *third* area, however, the long-term influx of FMGs into the domestic medical education process has had a more pervasive, yet less apparent, influence. By filling a large portion of the vacancies in graduate medical education training positions, FMGs have alleviated pressure for an increase in the number of graduates from domestic medical schools.

The economic implications of the use of FMGs, as well as the economic implications of policies serving to restrict the availability of FMGs in the future, are directly related to the manner in which FMGs have been incorporated in the domestic system and the extent to which the structure of the system has been tailored to accommodate the expanding supply of FMGs. In many areas, the system has oriented itself around expectations of a continued and increasing influx of FMGs. Policies serving to reduce or cut off the influx will produce traumatic effects in the absence of complementary measures designed to ease the transition to any new form the system might take. Policies aimed at restricting the immigration of FMGs or at changing their basic characteristics or behavior patterns will quickly open up gaps where FMGs currently satisfy demands that are not met by the domestic educational and manpower structure. These will be most apparent in the three areas enumerated above.

In the *first* case, as the pool of undergraduate medical degree-holders seeking admission to graduate training programs has been augmented by the growing annual influx of FMGs, the capacity of the graduate medical education system has expanded. Interns and residents have been used to deliver patient care in these institutions and the manpower mix is different than it might have been otherwise. However, the impact on total resources allocation, output of services, and the quality of training and of patient services is not completely clear. Efforts to determine the effect of graduate training on hospital performance (and its cost) have been made, but the evidence is cursory and nonconclusive.

A similar situation exists with regard to our knowledge of the *second* main area of FMG utilization, namely, the impact of FMGs on health care delivery in public institutions (e.g., State mental hospitals). These are said to be dependent on a manpower pool of FMGs who are not fully qualified to practice medicine. The existence of a market served by FMGs not fully licensed to practice is documented by the fact that the demand of public institutions for physician manpower is often accommodated by special licensure provisions, but neither the extent of this FMG subgroup nor the impact it has had on resources allocation is known. Anecdotal evidence suggests that much health care delivery in the public sector is dependent on the marginally qualified physician who is willing to accommodate (at least temporarily) to working conditions which better qualified individuals are in a position to reject.

Lack of objective evidence as to the impact of FMGs on health care delivery precludes meaningful quantitative statements regarding their effect on resources allocation. It seems clear, however, that policies aimed at quantity restriction or quality improvement will be manifested in a decrease in the supply of manpower in the particular sectors of the health care delivery system noted above. Responses to a decrease in the supply of a particular type of health manpower can be expected to lead to attempts to substitute other types of inputs in the delivery process.

Opportunities to substitute the services of other health manpower for those of physicians in the two settings considered above may be severely limited by legal restrictions as well as by the availability of admissible alternative manpower occupations. Within these limitations, the range of substitution may be further restricted by reluctance to accept any deterioration of quality of care or service that may be perceived to result from substitution of alternative

health manpower for physicians. The primary economic impact of FMG policies in these settings depends for the most part on how the substitution question is resolved. It will also depend somewhat on how legal, technological, and economic conditions are affected by companion policies designed to minimize the disruptions caused by a sudden change in the labor supply.

Research into possibilities for substitution and reorganization of labor-intensive health care processes, in order to effect greater productivity of health manpower, is currently being conducted under the general rubric of "task delegation." The problem of adjustment to an FMG policy which reduces the availability of physician services is a task delegation problem in the strictest sense. This is so because, if output is to be maintained, such an adjustment will most likely be accomplished not by replacement with equivalent personnel but by delegation of tasks and responsibility to personnel at a lower level of the health manpower hierarchy. (Some attempts to assess the economic impact of FMGs have been based on estimates of their "replacement cost" — the cost which would have been incurred if all FMGs currently practicing in the United States had been produced domestically. Besides yielding entirely fictitious results, such techniques are misleading because they overlook the basic fact that the state of the system would bear no resemblance to what it is now, had it arisen in the absence of the historical influx of FMGs.) In any case, solution of adjustment problems will require both innovation in those methods of producing patient care services currently resulting from processes utilizing FMGs and changes in legal restrictions preventing task delegation.

As noted above, the long-term influx of FMGs can be seen to have had a pervasive effect in a *third* area — the capacity of domestic undergraduate medical education. Insofar as State funding is concerned, for example, each State must consider the impact of its expenditure on the number of physicians practicing in the State. Because of the substantial interstate migration of physicians between the periods of undergraduate and graduate training, and between the periods of graduate training and establishment of practice, the link between support of undergraduate medical training and the actual number of physicians practicing in a State is often tenuous at best. The fact that many States must produce several undergraduate physicians for every one who ultimately becomes a practicing physician in that State — and the fact that many other States are able to attract physicians almost independent of their investments in undergraduate medical education — tends to induce a general underinvestment in undergraduate medical education when viewed from the national or aggregate perspective.

The perverse result of the absence of coordinated decision-making among States regarding production of undergraduate physicians can be aggravated by the influx of FMGs, in that unplanned and unregulated physician supply from a source outside the domestic education system tends to confound even more the relation between a State's contribution to support of undergraduate medical education and the number of practicing physicians it is able to attract. States which experience losses of undergraduate physicians trained at least in part at public expense may perceive that attracting graduate medical students into the State will prove more effective and more efficient than producing their own. Thus, in many instances, emphasis might be shifted from support of undergraduate education to funding for graduate training programs from which direct benefits are realized in the form of patient services and which are a better investment from the viewpoint of attracting permanent physicians.

While the influx of FMGs has added to domestic physician supply, therefore, it has also aggravated one condition which has led to a chronic underinvestment in domestic undergraduate medical education capacity. Consequently, a policy which has the effect of reducing the rate of influx of FMGs will be imposed on a medical education system which has a significantly smaller productive capacity than it otherwise might have had. Such a policy, therefore, should be accompanied by corollary policies designed to minimize the disruptions in domestic undergraduate medical education, graduate medical education, and health care delivery in general.

Health Care Implications

In addition to the issue of the increasing number of FMGs in the U.S. health care system, some observers, especially those in the medical profession, have raised questions about the quality of care provided by a number of FMGs. Although there are always notable exceptions, many feel that physicians who do not speak English fluently and who have not received training that is oriented to U.S. health care problems and practices, are not as capable of providing health care services as physicians trained in the United States. In light of the cultural differences and communications difficulties encountered by those FMGs for whom English is a second language, widely varying performance might be anticipated.

At least one study evaluating approaches to the measurement of quality of care in terms of physician performance stresses the importance of the ability of

the physician and patient to communicate (9). This is particularly noted in the provision of psychiatric care, where the ability of the patient and the physician to communicate seems crucial.

FMGs who have been able to obtain only a temporary or limited license are known to be working in State mental hospitals in large numbers. A recent judicial decision (discussed in Chapter III of this report) may prohibit the use of these temporarily licensed FMGs in the future. Clearly, State mental hospitals and other chronic care hospitals, county hospitals, and tuberculosis sanatoria represent areas where an acute physician manpower shortage would exist today if FMGs could not be utilized.

Redistribution of physician manpower within and among the several States and among specialties and subspecialties is a current topic of great interest within the medical profession and government agencies at all levels. Similarly, utilization of physician assistants or extenders and other health personnel — either traditional (such as the psychiatric social worker) or newly developing (such as the child health associate) — is also the subject of intensive discussion and investigation. At

the present time, implementation and evaluation of policies or programs related to these topics can proceed somewhat independent of the FMG issue, although, of course, continued reliance on FMGs in certain types of service settings impinges on redistribution and utilization planning. The more critical issue to address is the obverse situation: policies and action alternatives which would decrease the use of FMGs will have to be accompanied by policies and actions to redistribute physician manpower and to generate new patterns of health manpower organization. Otherwise, the maldistribution of physicians in certain specialty areas and practice settings would most probably be aggravated.

The FMG question is complex, and has no simple answers. Such answers as are devised to address all the implications of the FMG issue must take account of an intricate set of facts and suppositions about FMGs and their place in the U.S. health care system. The remainder of this report attempts to provide background information about those facts and suppositions, by describing the role of the FMG as a component of U.S. physician manpower supply and by discussing possible action alternatives that might be considered for policy formulation.

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CHAPTER



THE FOREIGN MEDICAL GRADUATE COMPONENT
OF U.S. PHYSICIAN MANPOWER

As of 1970, foreign medical graduates (FMGs) constituted just under one-fifth of all physicians in the United States (Table 1). They tended to be concentrated in hospital-based delivery of medical care; about one-third of all physicians in hospital-based practice (i.e., interns, residents, and full-time staff) were FMGs. At the end of 1970, some 28,400 of the 63,390 physicians from foreign schools (including Canada) were working full-time in U.S. hospitals. Of these, about 17,250 were interns and residents.

Most foreign-trained physicians now entering the United States do so early in their careers. Some of these physicians undoubtedly come with the intention of remaining; for most of these, a hospital post is one means of assimilation into the U.S. medical profession. Others intend to return home, and do so. But many have no clear-cut career intentions — or they change their intentions (generally to remaining in the United States) as they move through their graduate medical education. Thus, the impact of the internship and residency (and to a lesser degree other hospital positions) is a critical factor in the process of physician migration. For this reason, FMGs in graduate medical education will be singled out later in this report.

Table 1
FOREIGN MEDICAL GRADUATES IN
COMPARISON WITH ALL PHYSICIANS
IN THE UNITED STATES,
by major professional activity: 1970

Major professional activity	Foreign medical graduates ¹	All physicians	Foreign medical graduates as percent of all physicians
Total physicians	63,391	334,028	19.0
Patient care	52,913	278,535	19.0
Office-based practice	24,490	192,439	12.7
Hospital-based practice	28,423	86,096	33.0
Interns & residents	17,259	51,228	34.9
Full-time staff	11,164	34,868	32.0
Medical teaching	1,142	5,588	20.4
Administration . .	1,491	12,158	12.3
Research	3,608	11,929	30.2
Other	527	2,635	20.0
Inactive, unknown	3,710	23,183	16.0

¹ Including Canadians.

Source: Reference 1.

INTERNATIONAL EDUCATIONAL EXCHANGE AND IMMIGRATION

Nonimmigrant Visas and Exchange Visitors

Foreign-born FMGs are admitted to the United States both as immigrants (permanent residents) and as nonimmigrants (primarily exchange visitors). Exchange visitors enter under a special visa category, the 'J' visa, authorized by the U.S. Information and Educational Exchange (Smith-Mundt) Act of 1948 (amended several times but still in force today). Although intended initially for university-level students, this exchange visitor program has become a significant vehicle for the entry of physicians into graduate educational programs (i.e., internships and residencies). In the 12 years ending June 1973, some 55,360 physicians entered this country on exchange visitor (J) visas (Table 2), the great majority for graduate medical education. Only a comparatively small number (about 11 percent in FY 1973,

for example) enter in some other nonimmigrant category, such as "industrial trainees" or "workers of distinguished merit and ability." Since 1967, about 47 percent of all physicians entering the United States were immigrants, and 49 percent were exchange visitors. This has begun to change, however. In FY 1971-73, of all physicians entering the country, more physicians were admitted as immigrants (58 percent) than as exchange visitors (38 percent).

The process of remaining in the United States as a permanent resident has been facilitated by the recent change in the requirement that all physicians holding 'J' visas be absent from the United States for two years after their studies have ended before they can reenter the U.S. In 1970, legislation (P.L. 91-225) was passed to eliminate this requirement for persons coming to the

United States on private funds, as long as they were not from countries where their special skills were in short supply (24). If the exchange visitor was sponsored by funds from the United States or a foreign government, or if the Secretary of State determines that his services are clearly required at home, that person must return to his home country for the two-year period (unless he is granted a special waiver on the recommendation of the Secretary of State to the Immigration and Naturalization Service). The great majority of physicians in the United States as exchange visitors are privately funded, however, and this new legislation (P.L. 91-225) which represents the most recent amendment to the Smith-Mundt Act, is in effect a relaxation of previous restrictions on permanent immigration of physicians.

Countries determined by the U.S. Secretary of State to require the services of exchange visitor physicians are placed on the "Skills List," mandated by P.L. 91-225 (Figure 1). Published in the Federal Registry of 25 April 1972, it went into effect 25 May 1972. (It should be noted that countries requiring the services of other health manpower personnel, e.g., nurses, and not including physicians also can be placed on the Skills List.)

Table 2
FOREIGN PHYSICIANS AND SURGEONS
ADMITTED TO THE UNITED STATES
IN COMPARISON WITH NUMBER OF
U.S. MEDICAL GRADUATES:
1962-73

Fiscal year	U.S. medical graduates	Foreign physicians ¹			
		Total	Immigrants	Nonimmigrants	Exchange Other visitors
Total	97,809	101,066	43,089	55,360	2,617
1962 ...	7,168	5,767	1,797	3,970	N.A.
1963 ...	7,264	6,730	2,093	4,637	N.A.
1964 ...	7,336	6,767	2,249	4,518	N.A.
1965 ...	7,409	6,172	2,012	4,160	N.A.
1966 ...	7,574	6,922	2,552	4,370	N.A.
1967 ...	7,743	8,897	3,326	5,204	367
1968 ...	7,973	9,125	3,128	5,701	296
1969 ...	8,059	7,515	2,756	4,460	299
1970 ...	8,367	8,523	3,158	5,008	357
1971 ...	8,974	10,947	5,756	4,784	407
1972 ...	9,551	11,416	7,143	3,935	338
1973 ...	10,391	12,285	7,119	4,613	553

¹ Including Canadians.

Source: Reference 22. Unpublished data from the U.S. Department of Justice, Immigration and Naturalization Service.

Figure 1
EXCHANGE - VISITOR SKILLS LIST

Medical Skills list in Part I of the full Exchange-Visitor Skills List are as follows:

- 1F. Hospital Administration
- 2A. General Practice of Medicine
- 2B. Recognized Medical Specializations (including, but not limited to: Anesthesiology, Dermatology, Internal Medicine, Neurological Surgery, Obstetrics and Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Plastic Surgery, Preventive Medicine, Proctology, Psychiatry and Neurology, Radiology, Surgery, Thoracic Surgery, and Urology.)
- 2C. Nursing (including, but not limited to: Registered nurses, Practical nurses, Physician's receptionists, and Medical records clerks.)
- 2D. Medical Technology
- 2E. Dentistry
- 2F. Dental Technology
- 2G. Optometry
- 2H. Chiropractic and Osteopathy
- 2I. All Therapies, Prosthetics, and Healing (except Medicine, Nursing, Dentistry, Chiropractic, Osteopathy, and Optometry)
- 2U. Teaching in Medical Schools (including but not limited to, lecturers)
- 4B. Life Sciences (including but not limited to Pharmacy and Biology)

(Continued)

Figure 1 (Continued)
EXCHANGE – VISITOR SKILLS LIST

The fields of specialized medical knowledge or skill clearly required by each country are as follows:

Country	Medical Skills											
	1F	2A	2B	2C	2D	2E	2F	2G	2H	2I	2U	4B
Afghanistan	X	X	X	X	X	X	X	X		X	X	X
Algeria	X	X	X	X	X	X	X	X	X	X	X	X
Argentina	X											X
Bahrain	X	X	X	X	X	X	X	X	X	X		X
Bangladesh	X	X	X	X	X	X	X	X			X	X
Bolivia	X	X	X	X	X	X	X	X	X	X	X	X
Botswana	X	X	X	X	X	X	X	X	X	X	X	X
Brazil	X	X	X	X	X	X	X	X	X	X	X	X
Bulgaria	X	X	X	X	X	X	X	X	X	X	X	X
Burundi	X	X	X	X	X	X	X	X	X	X	X	X
Cameroon	X	X	X	X	X	X	X	X		X	X	X
Central African Republic	X	X	X	X	X	X	X	X	X	X	X	X
Ceylon												
Chad	X	X	X	X	X	X	X	X	X	X	X	X
Chile	X		X	X		X				X	X	X
Colombia			X	X	X	X	X					
Costa Rica	X	X	X	X	X	X	X	X	X	X	X	X
Cyprus	X	X	X	X	X	X	X	X	X	X		X
Czechoslovakia	X	X	X	X	X	X	X	X			X	X
Dahomey	X	X	X	X	X	X	X	X	X	X	X	X
Dominican Republic	X	X	X	X	X	X	X	X	X	X	X	X
Ecuador					X	X						
El Salvador	X	X	X	X	X	X	X	X		X	X	
Equatorial Guinea	X	X	X	X	X	X	X	X	X	X	X	X
Fiji			X	X	X	X	X	X	X	X	X	X
Gabon	X	X	X	X	X	X	X	X	X	X	X	X
Gambia	X	X	X	X	X	X	X	X	X	X	X	X
Ghana	X	X	X	X	X	X	X	X	X	X	X	X
Guatemala		X	X	X	X	X	X			X	X	X
Guinea	X	X	X	X	X	X	X	X	X	X	X	X
Guyana	X	X	X	X	X	X	X	X	X	X		X
Honduras	X	X	X	X	X	X	X	X	X	X	X	X
Hungary	X	X	X	X	X	X	X	X	X	X	X	X
India	X	X	X	X	X	X	X	X			X	
Indonesia	X	X	X	X	X	X	X	X	X	X	X	X
Iran	X	X	X	X	X	X	X	X	X	X	X	X
Ivory Coast	X	X	X	X	X	X	X	X		X	X	X
Jamaica	X	X	X	X	X	X	X	X			X	X
Jordan	X	X	X	X	X	X	X	X	X	X		X
Kenya	X	X	X	X	X	X	X	X	X	X	X	X
Khmer Republic	X	X	X	X	X	X	X	X				X
Korea		X		X	X							
Kuwait	X	X	X	X	X	X	X	X	X	X	X	X
Laos	X	X	X	X	X	X	X	X	X	X	X	X
Lebanon	X		X			X	X				X	
Liberia	X	X	X	X	X	X	X	X	X	X	X	X
Libya	X	X	X	X	X	X	X	X	X	X	X	X
Malawi	X	X	X	X	X	X	X	X	X	X	X	X
Malaysia	X	X	X	X	X	X	X	X	X	X	X	X
Mali	X	X	X	X	X	X	X	X	X	X	X	X
Malta	X		X	X	X	X					X	X
Mauritania	X	X	X	X	X	X	X	X	X	X		X
Mauritius	X	X	X	X	X	X	X	X	X	X	X	X

(Continued)

Figure 1 (Continued)
EXCHANGE-VISITOR SKILLS LIST

Country	Medical Skills											
	1F	2A	2B	2C	2D	2E	2F	2G	2H	2I	2U	4B
Morocco	X	X	X	X	X	X	X	X		X	X	X
Nepal	X	X	X	X	X	X	X	X	X	X	X	X
Nicaragua	X		X	X	X		X		X		X	X
Niger	X	X	X	X	X	X	X	X	X	X	X	X
Nigeria	X	X	X	X	X	X	X	X	X	X	X	X
Oman	X	X	X	X	X	X	X	X	X	X		X
Pakistan	X	X	X	X	X	X	X	X			X	X
Panama	X	X	X	X		X					X	
Paraguay	X		X	X	X		X			X		
Peru	X	X	X	X	X	X	X	X	X	X	X	X
Philippines		X	X	X ¹	X ²						X	
Poland	X	X	X	X	X	X	X	X	X	X	X	X
Qatar	X	X	X	X	X	X	X	X	X	X		X
Romania	X	X	X	X	X	X	X	X	X	X	X	X
Rwanda	X	X	X	X	X	X	X	X	X	X	X	X
Saudi Arabia	X	X	X	X	X	X	X	X	X	X	X	X
Senegal	X	X	X	X	X	X	X	X	X	X	X	X
Sierra Leone	X	X	X	X	X	X	X	X	X	X		X
Singapore	X	X	X					X			X	
Somalia	X	X	X	X	X	X	X	X	X	X	X	X
South Africa		X	X	X								
Sudan	X	X	X	X	X	X	X	X	X	X	X	X
Swaziland	X	X	X	X	X	X	X	X	X	X		X
Switzerland				X	X							X
Tanzania	X	X	X	X	X	X	X	X	X	X	X	X
Thailand	X	X	X	X	X	X	X	X	X	X	X	X
Togo	X	X	X	X	X	X	X	X	X	X	X	X
Tonga	X	X	X	X	X	X	X	X	X	X	X	X
Trinidad and Tobago	X	X	X	X	X	X	X			X		X
Tunisia	X	X	X	X	X	X	X	X	X	X	X	X
Turkey	X	X	X	X	X	X	X	X	X	X	X	X
United Arab Emirates	X	X	X	X	X	X	X	X	X	X		X
Upper Volta	X	X	X	X	X	X	X	X	X	X	X	X
Uruguay	X											
Venezuela	X	X	X	X	X	X	X				X	X
Vietnam	X	X	X	X	X	X	X	X	X	X	X	X
Zaire	X	X		X	X	X	X	X	X	X	X	X
Zambia	X	X	X	X	X	X	X	X	X	X	X	X

¹ Including only Pathology, Psychiatry and Neurology, Orthopedic Surgery, Thoracic Surgery, Surgery, Urology, and Internal Medicine.

² Including only registered nurses in a recognized nursing specialty.

Source: Department of State, Exchange-Visitor Skills List, Federal Register 37 (No. 80): 8099-8117, April 25, 1972.

In 1965, only about 1 of every 30 immigrant visas granted to physicians was to someone who was already an exchange visitor. By 1970, partly as the result of previous changes in legislation, the figure was 1 of every 6. In 1972, more than 1 of every 2 immigrant visas granted to physicians was to an exchange visitor still in

the U.S. It is thought that this reflects a backlog of exchange visitors who entered in FY 1970 or before and who were now able to change their visa status without leaving the country; only 13 percent of those changing from exchange visitor to immigrant status in 1972 had entered the country in 1971 or 1972.

One implication of this is that two avenues of entry into the U.S. can be utilized by physicians seeking permanent residence here. One is the "direct" immigrant route, in which the physician is admitted as a permanent resident when he enters the country initially. He may come in this category either for employment or for educational purposes. The second is the 'J' visa route, in which the physician enters as an exchange visitor (presumably only for educational purposes) and then may convert to immigrant status. It should be noted that, because of the ease of converting without the necessity of leaving the country, the total number of physicians entering this country in any given year will be overcounted by that number who enter and convert in the same year. For example, about 43 physicians counted as exchange visitors entering in 1972 are also counted as immigrants for 1972 by the Immigration and Naturalization Service (INS). This problem of overcounting is further compounded when one tries to estimate the total number of physicians entering the country over some extended period of time, because those admitted as immigrants in 1971 and 1972 included a substantial number of exchange visitors who had been in the country continuously for one or more years. Furthermore, for virtually all years since the inception of the Smith-Mundt Act, the group of physicians admitted as immigrants includes exchange visitors who left the country and then returned. These problems with quantifying the basic inflow of foreign physicians give some indication of the difficulties inherent in estimating the number and characteristics of FMGs in U.S. health care delivery and medical education.

Immigrant Visas

There are other complexities in the immigration process in addition to those presented by the nonimmigrant and immigrant categories, just discussed, particularly with regard to the laws affecting FMGs who enter as permanent residents. The Immigration Act of October 3, 1965 (P.L. 89-236) established two principal categories of immigrant visas, those subject to numerical limitations and those that are not subject to such limitations (5). Immigrant visas are numerically limited according to the hemisphere in which the alien was born. The annual visa limit for natives of the Eastern Hemisphere is 170,000 and for natives of the Western Hemisphere, 120,000. Close relatives of United States citizens (spouses, children, or parents) are exempt from these limitations regardless of hemisphere of birth.

The annual numerical limit for natives of the Eastern Hemisphere is 170,000 visas, assigned on the basis of seven preference categories. Four of the seven categories (first, second, fourth, and fifth) provide for the reunion of families of U.S. citizens and resident aliens. The seventh preference is allocated to refugees. The third preference category provides 17,000 visas for qualified immigrants who are members of the professions or who, because of exceptional ability in the sciences or the arts, could substantially benefit the U.S. national economy, cultural interests, or welfare. The sixth preference provides 17,000 visas for skilled or unskilled workers in short supply in the United States. The numerical limitation for these two preference categories includes the potential worker and his family members. The individual country ceilings for each nation in the Eastern Hemisphere is 20,000.

The visas for natives of the Western Hemisphere are allocated on a first-come, first-served basis, and applicants continue to exceed the number of available visas. As of June 1973, qualified applicants from the Western Hemisphere countries faced a waiting period of 22 months.

The Judiciary Committee of the U.S. House of Representatives, acting on the advice of the Subcommittee on Immigration and Nationality, in 1973 proposed amendments (HR 981) to the immigration laws which would bring the regulations for the Western Hemisphere more into line with those for the Eastern Hemisphere. In particular, it was agreed that the presently existing preference system for immigration from the Eastern Hemisphere be adopted for the Western Hemisphere. Although the total number of visas available for the latter would remain at 120,000, the maximum number of visas per country would be set at 20,000. The third and sixth preference categories, which are subject to labor certification, would each have 12,000 visas. One section of the proposed bill provides that refugees from Cuba who want to change their status to that of permanent resident may do so without a visa number, meaning that they would not count against the hemisphere ceiling of 120,000, as they presently do.

Labor Certification

Aliens who seek to immigrate to the United States on any basis other than a family relationship to U.S. citizens or lawful permanent residents, or as refugees, must obtain labor certification as provided in Section 212(a)(14) of the Immigration and Naturalization Act

of October 3, 1965 (6). This requirement extends to all "special immigrants" (i.e., those born in any independent foreign country of the Western Hemisphere or Canal Zone), all "non-preference" immigrants from the Eastern Hemisphere, and third and sixth occupational preference immigrants. These certifications, issued by the Secretary of Labor, reflect the dual concepts that there is a nationwide shortage of qualified workers in the United States and that wages and working conditions of U.S. workers similarly employed would not be adversely affected. The Department of Labor still classifies physicians in "Schedule A," which means that not enough workers in the United States as a whole are able, willing, qualified, and presently available for employment as physicians. On these grounds, the labor certification is granted to the FMG applicant after review of his qualifications. Successful completion of the ECFMG examination is used as a criterion of evaluating qualifications prior to issuance of labor certifications, if the applicant cannot furnish evidence of having met all requirements for licensure or for admittance to the licensure examination in the State of

the alien's intended employment. The requirement to obtain labor certification extended to about three-quarters of the FMGs admitted as immigrants in 1972 and 1973.

If it were determined by the Secretary of Labor that physicians are no longer in short supply on a nationwide basis, but only in specific geographic areas, then physicians would be removed from Schedule A. In this instance, each alien physician's application would be subject to individual review prior to his being admitted to the U.S. Provision of a labor certification would no longer be automatic upon meeting qualifications, but would be determined by the concentration of physicians in the geographical location designated by the alien as his intended place of residence. If that location has been designated a shortage area (for physicians), the Labor Department is responsible for assuring that there are no unemployed U.S. citizen physicians willing to relocate and accept employment in that location before it issues labor certification to the alien physicians.

EXAMINATIONS

The complexities of the foreign medical graduate situation in the United States cannot be understood without some appreciation of the role of two examinations: ECFMG (Educational Council for Foreign Medical Graduates) and FLEX (Federation Licensing Examination). The National Board of Medical Examiners also plays an indirect role in developing screening examinations for FMGs.

Educational Council for Foreign Medical Graduates (ECFMG)

In 1956, a Cooperating Committee on Graduates of Foreign Medical Schools (including members of the American Medical Association, the Association of American Medical Colleges, the American Hospital Association, and the Federation of State Medical Boards) endorsed the concept of an examination program to identify those FMGs (both U.S. and foreign-born) who are most likely to benefit from graduate medical training in the United States. The Educational Council for Foreign Medical Graduates (ECFMG) was set up to organize and administer a certification program which included a medical and English examination and a review of credentials; it began operation in October 1957 (7).

The medical examination questions are drawn from the pool of questions used in the tests given by the National Board of Medical Examiners. The standard for passing is set such that an expected 2 percent of U.S. medical students would not achieve the cut-off score of 75. FMGs have the option of retaking the examination until they achieve this passing score; more than 40 percent of the foreign physicians sitting for each examination are repeaters.

The ECFMG has become a major professional organization, giving examinations twice a year (usually February and September) in 42 centers in the United States, 7 in Canada, and over 125 in other countries (8). By the end of 1973, about 178,325 foreign-trained physicians had sat for the examination, and over 119,800 (or 67 percent) ultimately passed. In 1972 alone, 37,000 foreign-trained medical graduates took the examination, slightly more than one-half for the first time. Over the years, the percentage of candidates passing has varied from a low of 31 (in 1971) to a high of 46 (in 1967). The overall pass rate indicates that the examination does serve as a screening device, although there have been recommendations that it be made even more stringent (9).

Once the candidate passes the test, produces the required professional credentials, and clears his financial account, he is eligible to receive the ECFMG standard certificate. He can be awarded an interim certificate pending clearance of his financial account.

The ECFMG certification process is necessary in two different (although related) areas, namely, State licensure and appointment to hospital training programs. With regard to the former, ECFMG certification is listed by almost all of the 55 State and Territory licensure boards as part of the requirements for permanent licensure for physicians trained outside the United States or Canada (8, p. 55), although it can be waived in individual cases by all but 13 boards (8, p. 12). With regard to the latter, hospitals wishing to retain approved internship or residency programs and to appoint foreign-trained physicians to those programs must appoint only those with ECFMG certification or those with full and unrestricted State license to practice (10, p. 154). (The latter requirement is relaxed somewhat for U.S. citizens.) Similarly, accreditation of hospitals by the Joint Commission on Accreditation of Hospitals is dependent to some degree on hospitals employing only those foreign medical graduates with valid State licenses or ECFMG certification.

An "agreement of combination" was signed in November 1973 mandating the merger of the ECFMG and the Commission on Foreign Medical Graduates; the latter had been formed originally as an outgrowth of one recommendation of the 1967 National Advisory Commission on Health Manpower. The functions of the two organizations will continue, and the name will become the Educational Commission on Foreign Medical Graduates. The merger is expected to become effective by summer of 1974.

Federation Licensing Examination (FLEX)

One problem facing FMGs, in particular those FMGs desiring to remain as permanent residents and practice medicine in the U.S., has been the wide variation among States in licensing requirements. A desire to bring some degree of standardization into State requirements led to the development in 1968 of a new examination, the Federation Licensure Examination (FLEX). Like the ECFMG examination, it is based on the current pool of questions from the National Board of Medical Examiners; the FLEX questions are chosen to be of middle range in difficulty with emphasis on their practical value and clinical applicability (11, p. 18). FLEX is given in June and December of each year, over a three-day period. It is open to graduates of U.S.

medical schools and to FMGs and is designed for physicians who are in house staff positions or already in practice. By December 1973, all States (except Florida and Texas), the District of Columbia, Puerto Rico, and the Province of Saskatchewan, will use FLEX as their official board examination, and thus it will become the standard test for licensing for physicians who do not or cannot take the National Board examination. Legislation is required in the other two States and then FLEX will become universal. The total number of State licensure examinations administered in 1972 was over 18,500, the great majority being FLEX. Because of other requirements for licensure heretofore incumbent upon FMGs but not USMGs, however, it is not clear whether States will accept FMGs taking FLEX on the same terms as USMGs taking FLEX.

Some coordination between the ECFMG and FLEX is beginning to take hold. For example, the ECFMG will now accept for certification, any FMG who has passed FLEX with a grade of 75 or better and does not require him to take the ECFMG's own examination.

National Board of Medical Examiners

The National Board of Medical Examiners, which has been in existence for nearly 60 years, has as one major purpose the preparation and administration of qualifying examinations "of such high quality that legal agencies governing the practice of medicine within each State may, at their discretion, grant successful candidates a license without further examination" (11, p. 28). The qualifying examinations are given in three parts: Part I covers the basic sciences and Part II the clinical sciences. Part III is centered on clinical competence — i.e., interpretation of clinical data and management of problems. Any student or graduate from an approved medical school in the United States or Canada is eligible to register for the first two parts of the examinations. A candidate is eligible for the third part of the examination only if he has successfully completed the first two parts, received his M.D. degree, and served at least six months in an approved internship or residency.

The National Board also participates in a variety of other examination programs, including such activities as providing examinations for use by individual medical schools or departments and making available testing material for FLEX and ECFMG. As part of a continuing process of evaluating its role in licensure and specialty certification, the National Board has given careful consideration to the evaluation of foreign medical graduates. The National Board believes it should "pro-

mote the elimination of dual standards that now exist for USMGs and FMGs for admission to graduate medical education" (12, p. 67). A "Qualifying A" examination is to be devised "to evaluate performance characteristics requisite for providing patient care in a supervised setting." "Successful performance on Qualifying A" (among other things) would qualify a candidate for a "permit to practice in a supervised setting," and this permit would be required of all graduates (from both U.S. and foreign medical schools) for entrance into

residency training. Furthermore, the Goals and Priorities Committee of the National Board has agreed that an evaluation procedure is needed which will better assess English language capability and potential adjustment to the U.S. medical education and health care delivery system. To this end, the Committee recommended that a new evaluation instrument be designed, and successful performance on it would be a prerequisite for the Qualifying A examination for foreign-born FMGs.

THE DATA BASE

The comprehensiveness and accuracy of data on FMGs has still not yet reached a stage where subpopulations of FMGs can be reliably compared either with each other or with United States medical graduates (USMGs). Because of these limitations in the data presently available, FMGs are discussed in this paper generally on an aggregate basis. The FMG population is described in terms of a number of characteristics, such as country of origin, demographic characteristics, and major professional activity. A partial analysis of the relative performance of FMGs and USMGs is presented in terms of licensure, specialty board certification, and other indirect measures.

The reader is cautioned against drawing too firm conclusions about the characteristics or performance of FMGs, especially in comparison with USMGs. The deficiencies and liabilities of the data base, particularly in trying to look at FMGs over a long time, cannot be overstated.

Three major limitations of the FMG data base must be kept in mind. First is the problem of the enumeration of FMGs entering the U.S. In estimating the magnitude of the FMG flow into this country and the net FMG components of U.S. physician manpower, there are several obstacles to be surmounted. For example, with regard to the entry of FMGs into the United States over a several year period, the problem of double-counting must be recognized. That is, differentiations are not always made between those physicians who enter the country in one visa category and subsequently change to another at some later date, so they are counted twice and thereby inflate the total numbers. It must also be recalled that the exit of FMGs is not recorded in any systematic way which would allow the measurement of the annual net flow of immigrant or nonimmigrant physicians.

Second is the problem of an unknown but presumably sizeable number of FMGs who are functioning in the United States in some medical capacity, many in State mental or other long-term institutions, but who are "unknown" to any of the professional or regulatory bodies currently involved with FMGs. Thus, the information contained in this report is biased to the extent that it includes only those FMGs known to the AMA, the ECFMG, or the INS; it will readily be seen that these "known" FMGs comprise a segment of the total FMG population which has been more formally and visibly integrated into the U.S. health care system than the "unknown" segment.

Third, the data presented in this report on "known" FMGs are not always statistically comparable, because this "known" group of identified (or identifiable) FMGs is made up of different individuals, depending on the source of the information. That is to say, the INS data on immigration includes more physicians than are known to either the AMA or the ECFMG, and there are FMGs known to the ECFMG who are not known to the AMA (and vice versa). Appendix A, which depicts FMG immigration, education, and career pathways, illustrates more graphically some of the difficulties with the data base. A major effort is currently underway at Harvard University, under contract with the Division of Manpower Intelligence, Bureau of Health Resources Development, and in cooperation with the appropriate public and private agencies, to match as many FMGs as possible from these three sources and also to estimate the size of the "unknown" group.

The remainder of this chapter of the report will focus on demographic and professional characteristics of FMGs. That part of the FMG population serving in internships and residencies will be examined in somewhat more detail. In much of what follows, data are

given on USMGs for background and perspective, but it should be reiterated that statistical comparisons must not be made between FMGs and USMGs because of the inadequacies of the data base on the former group and because of the impossibility (at the present time) of controlling for certain key variables (especially age and sex). For example, differences with regard to specialty distribution or geographic distribution (especially rural/urban) may be explained, at least in part, by differences in the age and sex distribution. The FMG group, it will be seen, is younger and has more women than the USMG group, which might help to account for the urban concentration of FMGs. Were they compared with a group of USMGs matched for age and sex, for

example, it might appear that the FMGs were no more overrepresented in cities than the USMGs.

One major factor should be borne in mind with regard to the following discussions: unless otherwise noted, FMGs are considered to *include* Canadians on the grounds that the domestic source of physicians should be differentiated from any foreign source. Furthermore, many "Canadians" are actually natives of other countries and Canada may be only their last permanent residence. In some cases, data are available only for the U.S. and Canada combined versus other foreign countries (as, for example, in information from the AMA); where this occurs, it is so indicated in the text or the appropriate table.

FMGS AS A COMPONENT OF U.S. PHYSICIAN SUPPLY

Countries of Origin

When immigration figures are reported in terms of country or region of origin, they often refer to the immigrants' last permanent residence. At least two alternative interpretations are possible, however, especially where physicians are concerned: country of birth or country of medical education. Where country of origin is used in the analyses or tables based on the AMA report published in 1971 (1), it refers to country of graduation (medical education), and the countries are based on current political boundaries. In the discussion below, the immigration data are taken from the Immigration and Naturalization Service statistics in which country of origin is that of last permanent residence, unless otherwise indicated. Thus, the two major sources of data do not in general ascribe the same meaning to country of origin. Any given individual born in one country, educated in a second, and immigrating to the United States from a third might well appear under three different country listings, depending upon who was doing the enumeration — a not too unlikely example would be that of an Indian educated in England who entered the United States from Canada. Attention is drawn to these differences to highlight the fact that the reader should note carefully the meaning of country of origin in comparing figures on countries or regions from which foreign medical graduates are currently coming to the United States.

The past few years have witnessed a rapid increase in the number of physician immigrants (especially since 1965) and a dramatic rise in the proportion of physicians immigrating from the Far East and

South East Asia. Physicians on immigrant visas numbered about 2,000 a year between 1957 and 1965 (Table 3). In the latter year, about 1,000 were from Europe or Canada, and a mere 200 from all countries in Asia. Between 1965 and 1972, the annual number of physicians granted immigrant visas more than tripled, from 2,012 to 7,143. Within this total, European, Canadian, and other (African and Oceanian) immigration increased only a little and South American immigration dropped; immigration from Asian countries accounted for almost all the increase.

Table 4 and Appendix Table 1 give breakdowns by region and by country of last permanent residence of physicians admitted as immigrants for three recent years; the rise in physician immigration from India, Korea, Pakistan, Thailand, and Taiwan is clear. The immigration picture for 1972 has been distorted somewhat, however, because 1972 was the first complete fiscal year in which exchange visitors (who constitute by far the largest proportion of nonimmigrant physicians) were able to convert to immigrant status under P.L. 91-225.

Table 5 and Appendix Table 2 give somewhat differing views of 1972 physician immigration. Table 5 shows that in terms of region of birth, Asia is contributing more physicians to the total immigrant group than by region of last permanent residence (5,558, or 78 percent of the total, instead of 4,996, or 70 percent). Europe clearly is contributing fewer physicians and the same is also true of the Americas (9

percent by country of birth versus 13 percent by country of last permanent residence). Appendix Table 2 shows the substantial international migration of physicians among all the countries of the world. Of the 7,143

physicians admitted to the U.S. as immigrants in 1972, only 5,603 (or 78 percent) had the same country of birth and country of last permanent residence.

Table 3
FOREIGN PHYSICIANS AND SURGEONS ADMITTED TO THE UNITED STATES AS
IMMIGRANTS, BY COUNTRY OR REGION OF LAST PERMANENT RESIDENCE:
1953-72

Fiscal year	Total	United Kingdom	Other Europe	Canada	Mexico	Cuba	South America	Asia	Other
1953 ...	845	66	299	130	40	58	0	0	252
1954 ...	1,040	66	373	116	60	90	0	0	335
1955 ...	1,046	62	417	128	63	92	0	0	284
1956 ...	1,388	76	513	151	93	112	0	0	443
1957 ...	1,990	142	729	256	95	199	228	155	186
1958 ...	1,934	189	592	218	57	86	285	316	191
1959 ...	1,630	147	579	210	44	77	227	207	139
1960 ...	1,574	125	425	245	66	94	256	244	119
1961 ...	1,683	140	413	287	64	94	208	269	208
1962 ...	1,797	119	383	280	70	120	298	265	262
1963 ...	2,093	154	421	467	97	156	327	260	211
1964 ...	2,249	165	458	440	77	229	454	204	222
1965 ...	2,012	147	421	380	110	201	348	205	200
1966 ...	2,552	187	483	393	119	150	355	588	277
1967 ...	3,326	206	596	449	86	162	358	1,175	294
1968 ...	3,128	185	481	314	55	215	345	1,277	256
1969 ...	2,756	140	426	236	32	54	172	1,448	248
1970 ...	3,158	192	436	240	29	52	161	1,744	304
1971 ...	5,756	268	461	474	28	95	269	3,836	325
1972 ...	7,143	364	547	439	54	55	263	4,996	425

Source: Immigration and Naturalization Service and National Science Foundation.

Table 4
FOREIGN PHYSICIANS AND SURGEONS
ADMITTED AS IMMIGRANTS, BY REGION
OF LAST PERMANENT RESIDENCE:
1966, 1969, and 1972

Region of last permanent residence	Fiscal year					
	1966		1969		1972	
	Number	Percent	Number	Percent	Number	Percent
Total	2,552	99	2,756	100	7,143	100
Europe ..	667	26	579	21	911	13
Americas .	1,210	47	587	21	959	13
Asia	588	23	1,435	52	4,996	70
Africa ...	60	2	137	5	222	3
Oceania ..	24	1	18	1	55	1
Unknown	3	—	0	—	0	—

Source: Appendix Table 1.

Table 5
FOREIGN PHYSICIANS AND SURGEONS
ADMITTED AS IMMIGRANTS, BY REGION
OF BIRTH AND BY REGION OF LAST
PERMANENT RESIDENCE:
1972

Region	Region of birth		Region of last permanent residence	
	Number	Percent	Number	Percent
	Number	Percent	Number	Percent
Total ..	7,143	101	7,143	100
Europe ..	654	9	911	13
Americas .	626	9	959	13
Asia	5,558	78	4,996	70
Africa ...	259	4	222	3
Oceania ..	46	1	55	1

Source: Appendix Table 2.

The country-by-country breakdown (Appendix Table 2) substantiates the notion that certain countries act as way-stations for physicians immigrating to the United States from some third country; this is particularly true of the United Kingdom, Canada, and Taiwan, and possibly Libya, Hong Kong, and Israel. For example, 32 percent of those coming from Taiwan were born in some other Asian country, primarily Mainland China (13). Some 55 percent (243 of 439) of immigrant FMGs reporting Canada as the last permanent residence were from Asia, with 92 (21 percent) from India alone. Another 14 percent are from Europe. Similarly, 69 percent (251 of 364) of those from the United Kingdom listed their country of birth as an Asian country, again notably India (179, or 49 percent). Fourteen percent were born in another European country, and 12 percent in Africa (primarily Egypt). Thus, for a substantial fraction, the entrance into the U.S. constituted at least a second migratory step; for many, it was undoubtedly a third or fourth step.

Table 6 gives the number of physicians admitted as nonimmigrants who changed to immigrant status between 1966 and 1972. The steady rise in this category is clearly evident, with a major jump in 1971 and again in 1972 as a result of changes in immigration legislation noted earlier. Table 7 shows the proportion represented by this group of the total number of physicians admitted as immigrants for those years, highlighting the slight drop in 1968 and 1969 and the dramatic rise in 1971 and 1972.

Table 6
FOREIGN PHYSICIANS AND SURGEONS WHO
CHANGED FROM NONIMMIGRANT TO
IMMIGRANT STATUS,
BY REGION OF BIRTH:
1966-72

Region	Fiscal year						
	1966	1967	1968	1969	1970	1971	1972
Total	474	841	652	576	890	2,902	4,389
Europe	110	153	116	83	126	215	326
Americas ¹	28	86	76	15	43	75	47
Asia	295	567	436	461	679	2,529	3,861
Africa	30	27	20	15	39	73	128
Oceania	11	8	4	2	3	10	27

¹ Virtually all came from Cuba as refugees. Nonimmigrants from the Western Hemisphere are not allowed to change status while residing in the United States.

Source: Immigration and Naturalization Service and National Science Foundation data, Table D⁴, fiscal years 1966-72.

Table 7
NUMBER AND PERCENT OF
FOREIGN PHYSICIANS AND SURGEONS
ADMITTED AS IMMIGRANTS WHO CHANGED
FROM NONIMMIGRANT STATUS:
1966-72

Fiscal year	Total foreign physicians admitted as immigrants	Changed	Status
		Number	Percent
1966	2,522	474	19
1967	3,326	841	25
1968	3,128	652	21
1969	2,756	576	21
1970	3,158	890	28
1971	5,756	2,902	50
1972	7,143	4,389	61

Source: Tables 3 and 6.

Table 8 shows the number and percent of physicians admitted as permanent residents in 1972 by region of birth and visa status, indicating that only 39 percent of immigrants were in fact admitted as permanent residents directly from another country. The other 61 percent had changed from nonimmigrant to immigrant status while residing in the United States. This option (changing status while still living in the U.S.) is not open to citizens of countries in the Western Hemisphere (except for Cuban refugees), which explains the low number from the Americas who changed status. Among the "direct" immigrant group, 62 percent were from Asia (1,697 of 2,754); the other percentages were as follows: Americas, 21 percent; Europe, 12 percent;

Table 8
FOREIGN PHYSICIANS AND SURGEONS
ADMITTED AS IMMIGRANTS, BY REGION
OF BIRTH AND VISA STATUS:
1972

Region	Total	Changed status ¹		Direct immigrants	
		Number	Percent	Number	Percent
Total	7,143	4,389	61	2,754	39
Europe	654	326	50	328	50
Americas	626	47	8	579	92
Asia	5,558	3,861	69	1,697	31
Africa	259	128	49	131	51
Oceania	46	27	59	19	41

¹ Changed from nonimmigrant to immigrant status while residing in the United States.

Source: Immigration and Naturalization Service and National Science Foundation data, Table D1 and Table D4, fiscal year 1972.

Africa, 5 percent; and Oceania, 1 percent. Whether these patterns will continue is open to conjecture, but it will be important in future years to continue to differentiate the group which converts from nonimmigrant to immigrant status from the group which immigrates directly, whatever its size.

Physicians Table 9 and Appendix Table 3 give the breakdown of the 4,273 physicians admitted as nonimmigrants in 1972 by region and by country of origin. Although the number and percent of physicians from Asia is substantially higher than that from any other region, the preponderance is not nearly as marked as it is with the immigrant group. One clear difference between the immigrant group and the nonimmigrant group in 1972 is that, for the latter, the country of birth and country of last permanent residence corresponded much more closely; 92 percent of the nonimmigrants were born in and departed from the same country. For this group, then, it would appear that this is the first migratory step; for those who plan to convert to immigrant status after their arrival, it may well be the last.

Table 9
FOREIGN PHYSICIANS AND SURGEONS
ADMITTED AS NONIMMIGRANTS, BY
REGION OF BIRTH AND REGION OF
LAST PERMANENT RESIDENCE:
1972

Region	Region of birth		Region of last permanent residence	
	Number	Percent	Number	Percent
Total	4,273	100	4,273	99
Europe ..	1,046	24	1,039	24
Americas	1,011	24	1,078	25
Asia ...	1,976	46	1,936	45
Africa ...	169	4	143	3
Oceania .	71	2	77	2

Source: Appendix Table 3.

U.S.-born Foreign Medical Graduates The country of origin for U.S.-born foreign medical graduates (i.e., the country of medical education) is restricted almost entirely to those in Europe (Table 10); in 1970, some 89 percent of the U.S. FMGs had graduated from schools in 25 European countries. Italy and Switzerland together contributed 45 percent of the total foreign-educated group, and

Spain and the United Kingdom another 21 percent. Outside Europe, Mexico contributed the highest proportion of the U.S.-born foreign-trained physicians (7 percent). (These figures represent U.S. citizens returning to the United States after medical school abroad over quite a number of years prior to 1970, and thus they may reflect education or migratory patterns predominating in the 1960s or earlier. They are not strictly comparable to the 1972 immigration figures discussed above.)

Table 10
U.S.-BORN FOREIGN MEDICAL GRADUATES
IN THE UNITED STATES, BY COUNTRY OF
GRADUATION:
1970

Country of graduation	Number	Country of graduation	Number
Grand total	5,972		
Europe	5,342	Americas	485
Austria	194	Argentina	4
Belgium	208	Brazil	4
Czechoslovakia	10	Chile	7
Denmark	3	Colombia	4
East Germany	53	Costa Rica	1
Finland	2	Cuba	25
France	115	Dominican Republic	18
Greece	41	Haiti	2
Hungary	21	Jamaica	2
Iceland	1	Mexico	413
Ireland	151	Panama	1
Italy	1,375	Peru	2
Netherlands	232	Venezuela	2
Norway	2		
Poland	9	Asia	119
Portugal	10	China	18
Romania	5	Israel	3
Spain	622	Japan	29
Sweden	2	Lebanon	36
Switzerland	1,338		
Turkey	1	Philippines	28
USSR	16	South Korea	1
United Kingdom	667	Taiwan	3
West Germany	253	Thailand	1
Yugoslavia	11		
Oceania	18	Africa	8
Australia	18	Rhodesia	1
		South Africa	6
		Egypt	1

Source: Reference 1.

Selected Characteristics

Although performance in medical care delivery is the key criterion on which USMGs and FMGs might be compared, certain demographic or other descriptive

factors are also of interest. Reviewed here are age, sex, major professional activity, specialty, and geographic location.

Following the presentation of the data on the entire FMG group for the factors noted above, the subgroup of FMGs in graduate medical education (specifically, internships and residencies) will be examined separately. The distribution of FMGs in training programs by geographic location, hospital affiliation status, and specialty will be given particular attention. Although this approach does result in some duplication of the topics covered for the entire FMG group, because of the

crucial importance that hospital training positions have for FMGs in the U.S., it is felt that this additional examination is warranted.

Age The FMG population, on the average, is younger than the USMG population, as can be seen in Table 11. In 1963, some 49 percent of FMGs were under 40, compared with 37 percent of USMGs. In 1967, the figures were 50 percent and 36 percent; in 1970, the figures were 46 percent and 37 percent. The distribution of physicians by age groups and country of graduation for three selected years is given in Table 12, with percentages for each age.

Table 11
PHYSICIANS IN THE UNITED STATES UNDER AND OVER 40,
BY COUNTRY OF GRADUATION:
1963, 1967, and 1970

Age group	U.S. medical graduates		Foreign medical graduates ¹	
	Percent	Number	Percent	Number
	1963			
All ages	238,571	100	36,569	100
Under 40	88,894	37	17,899	49
Over 40	149,677	63	18,670	51
	1967			
All ages	255,104	100	51,866	100
Under 40	92,151	36	26,042	50
Over 40	162,953	64	25,824	50
	1970			
All ages	270,637	100	63,391	100
Under 40	99,536	37	28,946	46
Over 40	171,101	63	34,445	54

¹ Including Canadians.

Source: References 1 and 14.

In analyzing the FMG group, it is clear that most enter the United States early in their careers, which is consistent with the notion that most come with the initial intention of obtaining advanced medical training. Up to 1970, the majority (37,366 or 59 percent) had graduated from medical school within the previous 15 years, and 40 percent since 1960 (1, pp. 165, 277). In general, those countries contributing the largest number of immigrant physicians to the United States are also contributing the largest number of those recently graduated, including the Philippines, India, Canada, Korea, Iran, and Thailand (1). This age differential has implications for the United States, and even more significant implications for the donor countries, which are losing not just doctors, but young doctors.

Sex Members of the medical profession in the United States are predominantly male, but this tends to be more true of Americans than of foreign graduates. In 1963, for example, the percentage of females among the foreign medical graduates (including Canadians) was markedly higher (12 percent) than among U.S. graduates (5 percent) (Table 13). In 1967, the figures were 13 percent and 6 percent; in 1970, the comparable figures were 15 percent and 6 percent. When only those under the age of 40 are considered, the difference between USMGs and FMGs in terms of sex distribution is somewhat more striking (Table 14). In 1963, the proportion of women among the foreign medical graduates under 40 was 12 percent compared with 5 percent for the Americans. For 1967, the figures

were 15 percent and 6 percent; for 1970, the figures were 18 percent and 5 percent (although the latter is based on estimated numbers only).

Changing the frame of reference from U.S. versus foreign medical graduates to female versus male physicians gives similar evidence of a larger foreign component among women physicians than among men. In 1963, among the women medical graduates as a group, the proportion who were foreign graduates was 25 percent and among the men 13 percent (14). These figures have risen steadily over the years. The respective proportions of women and men who were FMGs were 32 percent and 16 percent in 1967, and 36 percent and 18 percent in 1970. Among women under 40, the proportion in 1963 who were foreign graduates was 31

percent; among the men, 16 percent. By 1967, among the women under 40, the proportion who were foreign graduates was still higher (44 percent) than among the men (20 percent). For 1970, the proportion (based on estimated figures) are 51 and 20 percent, respectively.

In summary, then, two trends seem to be clear. There are relatively more women among the foreign medical graduates than among the U.S. medical graduates, especially at the younger ages. In addition, among the female physicians as a group, there are more foreign graduates than among the male physicians as a group. More detailed analysis in terms of activity and location would be required before any inferences might be drawn about the implications of this sex differential for health care delivery in the United States.

Table 12
PHYSICIANS IN THE UNITED STATES,
BY AGE GROUP AND COUNTRY OF GRADUATION:
1963, 1967, and 1970

Age group	All physicians in the U.S.	U.S. medical graduates		Foreign medical graduates ¹	
		Number	Percent	Number	Percent
1963					
All ages	275,140	238,571	87	36,569	13
Under 30	30,262	25,239	83	5,023	17
30 - 39	76,531	63,655	83	12,876	17
40 - 49	66,574	59,433	89	7,141	11
50 - 59	51,273	44,983	88	6,290	12
60 - 69	29,249	25,584	87	3,665	13
70 and over	21,251	19,677	93	1,574	7
1967					
All ages	306,970	255,104	83	51,866	17
Under 30	34,615	26,909	78	7,706	22
30 - 39	83,578	65,242	78	18,336	22
40 - 49	75,697	63,703	84	11,994	16
50 - 59	55,661	48,196	87	7,465	13
60 - 69	34,918	30,804	88	4,114	12
70 and over	22,501	20,250	90	2,251	10
1970					
All ages	334,028	270,637	81	63,391	19
Under 30	38,569	32,831	85	5,738	15
30 - 39	89,913	66,705	74	23,208	26
40 - 49	82,108	64,558	79	17,550	21
50 - 59	58,485	50,489	86	7,996	14
60 - 69	40,056	34,447	86	5,609	14
70 and over	24,897	21,607	87	3,290	13

¹ Including Canadians.

Source: References 1 and 14.

Table 13
PHYSICIANS IN THE UNITED STATES,
BY SEX AND COUNTRY OF GRADUATION:
1963, 1967, and 1970

Sex	All physicians	U.S. medical graduates ¹		Foreign ¹ medical graduates	
		Number	Percent	Number	Percent
1963					
Both sexes	275,140	238,571	100	36,569	100
Men . .	257,818	225,511	95	32,307	88
Women	17,322	13,060	5	4,262	12
1967					
Both sexes	306,970	255,104	100	51,866	100
Men . .	285,566	240,608	94	44,958	87
Women	21,404	14,496	6	6,908	13
1970					
Both sexes	334,028	270,637	100	63,391	100
Men . .	308,627	254,444	94	54,183	85
Women	25,401	16,193	6	9,208	15

¹ Including Canadians.

Source: References 1 and 14. ✓

Table 14
PHYSICIANS IN THE UNITED STATES
UNDER 40 YEARS OF AGE,
BY SEX AND COUNTRY OF GRADUATION:
1963, 1967, and 1970

Sex	All physicians under 40 years of age	U.S. medical graduates		Foreign medical graduates ¹	
		Number	Percent	Number	Percent
1963					
Both sexes	106,793	88,894	100	17,899	100
Men . . .	99,742	84,014	95	15,728	88
Women . .	7,051	4,880	5	2,171	12
1967					
Both sexes	118,193	92,151	100	26,042	100
Men	109,079	87,009	94	22,070	88
Women . .	9,114	5,142	6	3,972	15
1970					
Both sexes ²	129,300	100,354	100	28,946	100
Men	119,150	95,415	95	23,735	82
Women . .	10,150	4,939	5	5,211	18

¹ Including Canadians.

² Estimated active physicians only.
Source: References 1 and 14.

Table 15
FOREIGN MEDICAL GRADUATES IN COMPARISON WITH ALL PHYSICIANS
IN THE UNITED STATES, BY MAJOR PROFESSIONAL ACTIVITY AND
COUNTRY OF GRADUATION:
1970

Major professional activity	Total physicians		U.S. medical graduates		Foreign medical graduates ¹	
	Number	Percent	Number	Percent	Number	Percent
Total	334,028	100.0	270,637	100.0	63,391	100.0
Patient care	278,535	83.4	225,622	83.4	52,913	83.4
Office-based practice	192,439	57.6	167,949	62.1	24,490	38.6
Interns and residents	51,228	15.3	33,969	12.6	17,259	27.2
Full-time physician staff	34,868	10.4	23,704	8.8	11,164	17.6
Other professional activity ...	32,310	9.7	25,542	9.4	6,768	10.7
Medical teaching	5,588 [*]	1.7	4,446	1.6	1,142	1.8
Administration	12,158	3.6	10,667	3.9	1,491	2.4
Research	11,929	3.6	8,321	3.1	3,608	5.7
Other	2,635	0.8	2,108	0.8	527	0.8
Not classified	358	0.1	73	- ²	285	- ²
Inactive	19,621	5.9	17,330	6.4	2,291	3.6
Address unknown	3,204	1.0	2,070	0.8	1,134	1.8

¹ Including Canadians.

² Less than 0.05 percent.

Source: Reference 1.

Major Professional Activity Foreign medical graduates in house staff or other full-time hospital positions are a major aspect of the whole medical migration phenomenon, because these positions act as a point of ready access to permanent practice in the United States. By no means are all foreign physicians in hospital practice, however; nearly 25,000 of 63,391 (or 39 percent) foreign medical graduates (including Canadians) were in office-based practice in 1970 (Table 15). Over 4,700 foreign-trained physicians (7 percent) were in medical teaching or research, and almost 1,500 (2 percent) in administration.

Taking all physicians as the frame of reference, only about 13 percent of the physicians in office practice in 1970 were graduates of foreign medical schools (Table 1). This percentage may be expected to increase in the future, however, as more physicians leave graduate educational posts and as requirements for State licensure become more standardized in terms of reciprocity. As of 1970, foreign medical graduates were most concentrated in hospital-based patient care, in that one-third of all physicians in that category were foreign medical graduates: 35 percent of the interns or residents and 32 percent of the full-time hospital staff. In addition, 30 percent of all physicians in research were foreign medical graduates, as were 20 percent of all physicians in medical teaching, and 12 percent of all physicians in administration.

Foreign medical graduates have long made a substantial contribution to American medical research. A study by West in the mid-1960s concluded that the United States was the recipient of substantial foreign aid in terms of the number of biomedical scientists (15). More studies in this area need to be done in light of the manpower and funding situation of the 1970s. Until recently, manpower studies of resources for medical research undertaken by the National Institutes of Health had taken little note of the substantial role of foreign medical graduates (16). The current effort in the Division of Manpower Intelligence, Bureau of Health Resources Development, to project the supply and output requirements for health manpower to 1990 is a major change of direction in this regard, however; FMGs occupy a central role in that analysis (17).

Specialty Total numbers of foreign medical graduates (including Canadians) compared by specialty with the total number of physicians in the United States for 1970 are presented in Table 16. A high proportion of FMGs in anesthesiology, pathology, pediatric cardiology, and physical medicine

is seen. FMGs as a whole are less often found in dermatology, occupational medicine, ophthalmology, orthopedic surgery, and public health.

The percentage distribution of FMGs by selected specialty (Table 17) indicates that about 40 percent of the total FMG group can be found in one of the five major specialties (internal medicine, pediatrics, general surgery, obstetrics and gynecology, and psychiatry). With the addition of general practice, about 52 percent of the FMG group is included. Roughly the same proportion of USMGs are in the five major specialties (38 percent), but the addition of general practice brings the total to 57 percent.

The distribution of foreign medical graduates (including Canadian) by specialty and major professional activity is given in Appendix Table 4. Table 18 presents the distribution of FMGs in selected specialties by major activity, indicating some differences by specialty among the three major activities. Some 47 percent of those FMGs in hospital-based practice (interns, residents, and full-time staff) are found in one of the five major specialties, compared with 40 percent of those in office-based practice and 34 percent of those in all other activities. When FMGs in general practice are added, however, the highest proportion of FMGs is found in office-based practice (64 percent) rather than hospital-based practice (53 percent) or other activities (36 percent).

Geographical Area One distinctive characteristic of American medicine is its locus in major cities. Foreign medical graduates, even more than their American counterparts, gravitate toward metropolitan areas. In 1970, for example, about 9 percent of all foreign medical graduates (excluding Canadians) were located in non-metropolitan areas. Approximately 15 percent of the non-Federal USMGs were located in nonmetropolitan areas. Of the resident population in 1970, about 26 percent could be found outside SMSAs (1, 18). Table 19 gives the distribution of FMGs (excluding Canadians) in metropolitan areas by region of medical education as of 1970. As noted earlier, almost 90 percent of all FMGs are located in cities, but among the FMG group, there is some variation as to location. Those FMGs educated in the Americas are rather more dispersed into the nonurban areas of America than the FMG group. On the other hand, those educated in India and Pakistan are notably more concentrated in the cities.

Table 16
 PHYSICIANS IN THE UNITED STATES, BY SPECIALTY AND COUNTRY OF GRADUATION:
 1970

Specialty	Total physicians	Foreign medical graduates ¹			Foreign medical graduates as percent of total physicians
		Canadians	Other	Total	
Total	334,028	6,174	57,217	63,391	19
General practice	57,948	770	6,742	7,512	13
Allergy	1,719	36	191	227	13
Cardiovascular diseases	6,476	101	1,249	1,350	21
Dermatology	4,003	83	388	471	12
Gastroenterology	2,010	41	390	431	21
Internal medicine	41,872	522	6,372	6,894	16
Pediatrics	17,941	245	3,542	3,787	21
Pediatric allergy	391	4	80	84	21
Pediatric cardiology	487	11	169	180	37
Pulmonary disease	2,315	46	618	664	29
General surgery	29,761	462	5,286	5,748	19
Neurological surgery	2,578	80	409	489	19
Obstetrics and gynecology	18,876	339	3,064	3,403	18
Ophthalmology	9,927	210	810	1,020	10
Orthopedic surgery	9,620	205	882	1,087	11
Otolaryngology	5,409	128	641	769	14
Plastic surgery	1,600	34	213	247	15
Colon and rectal surgery	667	22	62	84	13
Thoracic surgery	1,809	27	365	392	22
Urology	5,795	106	739	845	15
Aviation medicine	1,188	14	32	46	4
Anesthesiology	10,860	261	3,304	3,565	33
Child psychiatry	2,090	75	425	500	24
Diagnostic roentgenology	1,968	32	336	368	19
Forensic pathology	200	5	42	47	24
Neurology	3,074	89	624	713	23
Occupational medicine	2,713	80	179	259	10
Psychiatry	21,146	563	5,025	5,588	26
Pathology	10,283	247	3,132	3,379	33
General preventive medicine ..	804	17	90	107	13
Physical medicine and rehabilitation	1,479	27	501	528	36
Public health	3,029	64	261	325	11
Radiology	10,524	175	1,407	1,582	15
Therapeutic radiology	868	19	209	228	26
Other and unspecified	19,415	399	6,363	6,762	35
Inactive, unknown, and not classified	23,183	635	3,075	3,710	16

¹ Including Canadians.

Source: Reference 1. Balfe, B.E., Lorant, J.H., and Todd, C. Reference Data on the Profile of Medical Practice. Chicago: American Medical Association, 1971, pp. 6-8.

Table 17
PHYSICIANS IN THE UNITED STATES IN SELECTED SPECIALTIES, BY
COUNTRY OF GRADUATION:
1970

Specialty	Total physicians	Foreign medical graduates ¹		U.S. medical graduates	
		Number	Percent	Number	Percent
Total	334,028	63,391	100	270,637	100
Selected specialties and general practice ..	187,544	32,932	52	154,612	57
Selected specialties	129,596	25,420	40	104,176	38
Internal medicine	41,872	6,894	11	34,987	13
Pediatrics	17,941	3,787	6	14,154	5
General surgery	29,761	5,748	9	24,013	9
Obstetrics and gynecology	18,876	3,403	5	45,473	6
Psychiatry	21,146	5,588	9	15,558	6
General Practice	57,948	7,512	12	50,436	19
All other ²	146,484	30,459	48	116,025	43

¹ Including Canadians.

² Includes all other specialties, unspecified specialties, inactive, unknown, and not classified.

Source: Compiled from Table 16.

Note: Percentages may not add due to independent rounding.

Table 18
FOREIGN MEDICAL GRADUATES ¹ IN THE UNITED STATES IN SELECTED SPECIALTIES,
BY MAJOR PROFESSIONAL ACTIVITY:
1970

Specialty	Hospital-based practice		Office based Practice		Other activities	
	Number	Percent	Number	Percent	Number	Percent
Total	28,423	100.0	24,490	100.0	6,768	100.0
Selected specialties and general practice	14,922	52.5	15,560	63.5	2,450	36.2
Selected specialties	13,433	47.3	9,699	39.6	2,288	33.8
Internal medicine	3,576	12.6	2,699	11.0	619	9.2
Pediatrics	1,893	6.7	1,439	5.9	455	6.7
General surgery	3,454	12.2	2,013	8.2	281	4.2
Obstetrics/Gynecology	1,490	5.2	1,673	6.8	240	3.5
Psychiatry	3,020	10.6	1,875	7.7	693	10.2
General practice	1,489	5.2	5,861	23.9	162	2.4
All other ²	13,501	47.5	8,930	36.5	4,318	63.8

¹ Including Canadians.

² Including all other and unspecified specialties and excluding inactive, unknown, and not classified.

Source: Appendix Table 4.

Table 19
FOREIGN MEDICAL GRADUATES IN METROPOLITAN OR NONMETROPOLITAN AREAS
OF THE UNITED STATES, BY REGION OF ORIGIN:
1970

Region of origin	Total	Standard metropolitan statistical area		Non-standard metropolitan statistical area		Unknown	
		Number	Percent	Number	Percent	Number	Percent
All regions	57,217 ¹	51,053	89	5,186	9	978	2
Europe	24,756	21,898	88	2,555	10	303	1
Americas	9,927	8,192	83	1,312	13	423	4
Asia, total	20,829	19,368	93	1,235	6	226	1
India and Pakistan	4,741	4,543	96	157	3	41	1
All other	16,088	14,825	92	1,078	7	185	1
Africa	1,301	1,216	93	68	5	17	1
Oceania	404	379	94	16	4	9	2

¹ Excluding Canadians.
Source: Reference 1.

The uneven geographical distribution is also seen on a State-by-State breakdown (Tables 20 and 21). Taking the State of New York as a whole, for example, foreign medical graduates represented about 19 percent of all physicians in 1959 (19, p. 11); the proportion has risen steadily, such that in 1970, about 38 percent of physicians in the State were graduates of foreign schools (Table 20). Other States notable for a rising and substantial proportion of foreign-trained physicians are Rhode Island, Delaware, New Jersey, and Illinois. In contrast, States such as Arkansas, Idaho, Mississippi, and Utah have an inconsequential proportion of FMGs (19).

Of the total FMG population (including Canadians), almost 72 percent were distributed in 10 States, with New York having by far the largest share (Tables 21 and 22). U.S. medical graduates as of 1970 were not quite as heavily concentrated; 57 percent of the U.S. graduates were in 10 States. These were not all the same States as the FMGs, however, the top 10 States for U.S. medical graduates include Texas but not Maryland. The top ten States in proportion of either FMGs or USMGs did not take in as high a proportion of the U.S. resident population, however. About 51 percent of the U.S. population (as of December 31, 1970) was found in the 10 States with 72 percent of the FMGs; looking at the 10 States with the 57 percent of USMGs, some 55

percent of the population is included. This would appear to substantiate the notion that FMGs are concentrated in certain States (especially New York) beyond what might be expected in comparison with the distribution of either the resident population or USMGs, but this remains to be evaluated further, controlling for such variables as age, sex, and current professional activity.

Six States are among the top ten in both proportion of FMGs out of the total number of physicians in that State and in proportion of FMGs out of the total number of FMGs: New York, New Jersey, Illinois, Ohio, Michigan, and Maryland (Table 22). Other States having a high proportion of FMGs relative to the total number of doctors in the State are Rhode Island, Delaware, West Virginia, and Connecticut. The FMGs in these States are not necessarily in the same activities, however (Appendix Table 5). In some of these States, a relatively high proportion are filling house staff positions (e.g., Michigan). In other States, the proportion of FMGs in graduate medical education is lower (e.g., Delaware or West Virginia) and the FMGs in those States are more highly concentrated in office or hospital-based practice. (Appendix Table 5 should not be compared directly with Tables 20-22, because it does not include Canadians and the others do. A breakdown of Canadian graduates by activity and location was not available at the time this report was prepared.)

Table 20
NUMBER AND PERCENT OF PHYSICIANS IN EACH STATE, BY COUNTRY OF GRADUATION:
1970

State	Total physicians in State	U.S. medical graduates	Foreign medical graduates			Percent of physicians who are	
			Total	Canadians	Other	U.S. medical graduates	Foreign medical graduates
Total	334,028	270,637	63,391	6,174	57,217	81.0	19.0
Alabama	3,377	3,219	158	11	147	95.3	4.7
Alaska	324	303	21	4	17	93.5	6.5
Arizona	2,938	2,608	330	48	282	88.8	11.2
Arkansas	1,955	1,924	31	6	25	98.4	1.6
California	41,640	37,476	4,164	1,184	2,980	90.0	10.0
Colorado	4,386	4,076	310	51	259	92.9	7.1
Connecticut	6,072	4,617	1,455	188	1,267	76.0	24.0
Delaware	783	543	240	23	217	69.3	30.7
District of Columbia	4,073	3,253	820	42	778	79.9	20.1
Florida	11,451	9,513	1,938	169	1,769	83.1	16.9
Georgia	5,546	5,088	458	24	434	91.7	8.3
Hawaii	1,235	999	236	33	203	80.9	19.1
Idaho	718	697	21	10	11	97.1	2.9
Illinois	16,323	11,608	4,715	173	4,542	71.1	28.9
Indiana	5,470	4,954	516	43	473	90.6	9.4
Iowa	3,061	2,708	353	30	323	88.5	11.5
Kansas	2,910	2,582	328	29	299	88.7	11.3
Kentucky	3,560	3,192	368	22	346	89.7	10.3
Louisiana	4,768	4,476	292	31	261	93.9	6.1
Maine	1,186	903	283	109	174	76.1	23.9
Maryland	9,518	7,140	2,378	129	2,249	75.0	25.0
Massachusetts	12,576	10,227	2,349	351	1,998	81.3	18.7
Michigan	11,364	8,559	2,805	429	2,376	75.3	24.7
Minnesota	6,145	5,303	842	197	645	86.3	13.7
Mississippi	2,077	2,001	76	9	67	96.3	3.7
Missouri	6,314	5,283	1,031	49	982	83.7	16.3
Montana	787	743	44	14	30	94.4	5.6
Nebraska	1,855	1,777	78	8	70	95.8	4.2
Nevada	595	557	38	24	14	93.6	6.4
New Hampshire	1,098	857	241	96	145	78.1	21.9
New Jersey	10,923	7,565	3,358	134	3,224	69.3	30.7
New Mexico	1,390	1,242	148	21	127	89.4	10.6
New York	44,800	27,795	17,005	1,059	15,946	62.0	38.0
North Carolina	6,069	5,696	373	62	311	93.9	6.1
North Dakota	660	528	132	41	91	80.0	20.0
Ohio	14,740	10,996	3,744	228	3,516	74.6	25.4
Oklahoma	2,899	2,775	124	19	105	95.7	4.3
Oregon	3,181	2,981	200	59	141	93.7	6.3
Pennsylvania	18,712	15,779	2,933	223	2,710	84.3	15.7
Rhode Island	1,638	1,084	554	59	495	66.2	33.8
South Carolina	2,670	2,560	110	11	99	95.9	4.1
South Dakota	629	556	73	3	70	88.4	11.6
Tennessee	5,022	4,698	324	18	306	93.5	6.5
Texas	14,952	13,307	1,645	105	1,540	89.0	11.0
Utah	1,569	1,508	61	18	43	96.1	3.9
Vermont	868	756	112	41	71	87.1	12.9
Virginia	6,552	5,588	964	68	896	85.3	14.7
Washington	5,562	4,939	623	194	429	88.8	11.2
West Virginia	1,946	1,465	481	18	463	75.3	24.7
Wisconsin	5,588	4,893	695	53	642	87.6	12.4
Wyoming	364	346	18	5	13	95.0	5.0
Possessions	2,836	1,412	1,424	10	1,414	49.8	50.2
APO-FPO	3,149	2,912	237	33	204	92.5	7.5
Address unknown	3,204	2,070	1,134	156	978	64.6	35.4

Source: Reference 1.

Table 21
DISTRIBUTION OF U.S. MEDICAL GRADUATES
AND FOREIGN MEDICAL GRADUATES, BY STATE:
1970

State	U.S. medical graduates		Foreign medical graduates ¹		State	U.S. medical graduate		Foreign medical graduates ¹	
	Number	Percent	Number	Percent		Number	Percent	Number	Percent
Total	270,637	100.0	63,391	100.0	Missouri	5,283	2.0	1,031	1.6
Alabama	3,219	1.2	158	.2	Montana	743	.3	44	.1
Alaska	303	.1	21	— ²	Nebraska	1,777	.7	78	.1
Arizona	2,608	1.0	330	.5	Nevada	557	.2	38	.1
Arkansas	1,924	.7	31	— ²	New Hampshire	857	.3	241	.4
California	37,476	13.9	4,164	6.6	New Jersey	7,565	2.8	3,358	5.3
Colorado	4,076	1.5	310	.4	New Mexico	1,242	.5	148	.2
Connecticut	4,617	1.7	1,455	2.3	New York	27,795	10.3	17,005	26.8
Delaware	543	.2	240	.4	North Carolina	5,696	2.1	373	.6
District of Columbia .	3,253	1.2	820	1.3	North Dakota	528	.2	132	.2
Florida	9,513	3.5	1,938	3.1	Ohio	10,996	4.1	3,744	5.9
Georgia	5,088	1.9	458	.7	Oklahoma	2,775	1.0	124	.2
Hawaii	999	.4	236	.4	Oregon	2,981	1.1	200	.3
Idaho	697	.3	21	— ²	Pennsylvania	15,779	5.8	2,933	4.6
Illinois	11,608	4.3	4,715	7.4	Rhode Island	1,084	.4	554	.9
Indiana	4,954	1.8	16	.8	South Carolina	2,560	1.0	110	.2
Iowa	2,708	1.0	353	.6	South Dakota	551	.2	73	.1
Kansas	2,582	1.0	328	.5	Tennessee	4,698	1.7	324	.5
Kentucky	3,192	1.2	368	.6	Texas	13,307	4.9	1,645	2.6
Louisiana	4,476	1.7	292	.5	Utah	1,508	.6	61	.1
Maine	903	.3	283	.4	Vermont	756	.3	112	.2
Maryland	7,140	2.6	2,378	3.8	Virginia	5,588	2.1	964	1.5
Massachusetts	10,227	3.8	2,349	3.7	Washington	4,939	1.8	623	1.0
Michigan	8,559	3.2	2,805	4.4	West Virginia	1,465	.5	481	.8
Minnesota	5,303	2.0	842	1.3	Wisconsin	4,893	1.8	695	1.1
Mississippi	2,001	.7	76	.1	Wyoming	346	.1	18	— ²
					Other and Unknown .	6,394	2.4	2,795	4.4

¹ Including Canadians.

² Less than .05 percent.

Source: Reference 1.

Table 22
TEN HIGHEST RANKING STATES ON BASIS OF POPULATION,
FOREIGN MEDICAL GRADUATES, U.S. MEDICAL GRADUATES, AND
PROPORTION OF FOREIGN MEDICAL GRADUATES:
1970

State	Resident population 12/31/70		U.S. medical graduates		Foreign medical graduates ¹		Foreign medical graduates ¹	
	Rank	Percent of U.S.	Rank	Percent of total USMGs	Rank	Percent of total FMGs	Rank	Percent of all physicians in State
10 - State total ..		54.8		56.5		71.6		—
California	1	9.9	1	13.9	3	6.6	—	—
New York	2	8.9	2	10.3	1	26.8	1	38.0
Pennsylvania	3	5.7	3	5.8	6	4.6	—	—
Texas	4	5.6	4	4.9	—	—	—	—
Illinois	5	5.5	5	4.3	2	7.4	5	28.9
Ohio	6	5.2	6	4.1	4	5.9	6	25.4
Michigan	7	4.4	9	3.2	7	4.4	9	24.7
New Jersey	8	3.5	10	2.8	5	5.3	4	30.7
Florida	9	3.4	8	3.5	10	3.1	—	—
Massachusetts	10	2.8	7	3.8	9	3.7	—	—
Maryland	—	1.9	—	—	8	3.8	7	25.0
Rhode Island	—	—	—	—	—	—	2	33.8
Delaware	—	—	—	—	—	—	3	30.8
West Virginia	—	—	—	—	—	—	8	24.7
Connecticut	—	—	—	—	—	—	10	24.0

¹ Including Canadians.

Source: Tables 20 and 21. Roback, G.A., Distribution of Physicians in the U.S., 1971. Chicago: American Medical Association, 1972.

Note: Percentages may not add due to independent rounding.

It has been assumed that the influx of foreign medical graduates filled gaps in the geographical distribution of physicians in the United States. A study by Butter and Shaffner has questioned this assumption, however (20). The investigators compared the spatial distribution of all physicians with that of U.S.-trained physicians, making a distinction between the aggregate impact and the distributional impact of foreign-trained physicians. Their results indicated that in the Nation as a whole, foreign medical graduates have increased rather than decreased the inequality among States in terms of physician distribution. More than one-half of the foreign-trained physicians in the United States were located in States where their presence made the already existing inequalities among the States more extreme. The same held true for the inequalities between urban and rural areas.

The distribution of foreign medical graduates (excluding Canadians) by activity and State is given in Appendix Table 5. The proportion of FMGs in graduate medical education (i.e., internships and residencies) ranges between 20 and 39 percent for 30 of the States (Table 23). The District of Columbia, Louisiana, Michigan, Pennsylvania, and Arkansas all have over 40 percent of their FMGs in internships or residencies. Some 35 States have between 20 and 49 percent of their FMGs in office-based practice; Alaska, Maine, New Hampshire, North Dakota, South Dakota, and Wyoming all have more than 60 percent of their FMGs in office-based practice, however. Almost all the States, 45 of 51, have between 10 and 29 percent of their FMGs in hospital-based practice; only Arkansas, Idaho, Kentucky, Oklahoma, and South Carolina have more than 30 percent in such practice. Finally, some 44 States

have between 0 and 19 percent of their FMGs in other activities.

Table 23
NUMBER OF STATES PLUS THE
DISTRICT OF COLUMBIA BY PROPORTION
OF FOREIGN MEDICAL GRADUATES IN
SPECIFIED MAJOR PROFESSIONAL
ACTIVITY:
1970

Percent of foreign medical graduates in specified activity	Office- based practice	Full-time hospital practice	Interns and residents	Other activity
Total	51	51	51	51
0 - 9	2	1	8	23
10 - 19	3	19	8	21
20 - 21	12	26	16	6
22 - 39	12	4	14	1
30 - 49	11	1	4	0
50 - 59	5	0	1	0
60 - 69	3	0	0	0
70 - 79	3	0	0	0

Source: Compiled from Appendix Table 5.

Foreign Medical Graduates in Graduate Medical Education *

Background Primary responsibility for clinical graduate education of physicians in the United States, as elsewhere, rests with hospitals, with standards set and overseen by national professional groups (21). The internship has been claimed from time to time as the fifth year of medical school, although by the 1950s, most medical schools (although not State licensing boards) had dropped the internship as a requirement for the M.D. degree. In part because of the growing desire on the part of the medical profession for specialty recognition, emphasis has increasingly been placed on residency programs, and the connections between hospital training programs and medical schools have become more formalized. In 1960, for example, only 38 percent of the internships and 54 percent of the residencies were in hospitals affiliated with university medical schools. By 1972, however, 84 percent of the internships offered and 90 percent of the residencies

offered were in so-called "affiliated" hospitals. In terms of filled positions, 83 percent of the internships and 89 percent of the residencies were in affiliated hospitals (22).

Between 1940 and 1960, the number of physicians in internship and residency training programs trebled from fewer than 12,000 to nearly 38,000. By 1960, one of every seven physicians was an intern or resident. Since then, the rate of increase has slowed, but the aggregate number has nonetheless continued to grow until the number house staff in 1972 exceeded 56,000 (22).

This large number of physicians in internships and residencies does not give a completely accurate picture of the number of *potential* house staff, however. There are more approved internship and residency positions offered each year than there are physicians available to fill them. For example, at the internship level, there are now at least half again as many internship posts available as there are U.S. medical graduates (Table 24). In 1949-50, some 80 percent of the internships offered in the United States were filled; in 1959-60, the proportion was 82 percent, and in 1969-70, it was 72 percent. The most recent figure available is 82 percent (22, 23). For residencies, the decrease in filled positions has been somewhat more extreme. In 1949-50, for example, 94 percent of the positions were filled; in 1959-60, some 87 percent. By 1969-70, it had dropped to 82 percent, and currently it is 88 percent.

A substantially larger percent of the available residencies in nonaffiliated hospitals as opposed to those in affiliated hospitals (23 percent and 11 percent, respectively) were unfilled in 1971. Unfilled internships in nonaffiliated and affiliated hospitals were 22 percent and 17 percent, respectively.

The fact that at least 1,500 hospitals with graduate training programs determine the number of house staff positions to be offered (subject to the approval of the Council on Medical Education) needs to be stressed, for these uncoordinated decisions have had a direct impact on the number of foreign medical graduates now in the United States. (In addition, over 6,000 other hospitals in the United States offer a variety of employment positions, but these do not provide graduate medical education in the usual sense of internships, residencies, or other training.) Whatever the individual motivation behind a physician's decision to come to the United States, without a job offer most would probably have been unable to do so. Relatively permissive visa arrangements and requirements for professional certification

* Data presented in this section for years since 1970 are taken from recent AMA publications and do not include Canadians with other FMGs unless specified.

have facilitated, but not caused, the flow of foreign medical graduates into hospital training (or employment) positions. The figures noted in the preceding paragraphs indicate that a substantial pool of available house staff positions exists even after U.S. graduates have been accommodated.

Table 24
NUMBER OF APPROVED INTERNSHIPS
OFFERED IN THE UNITED STATES AND ITS
TERRITORIES AND POSSESSIONS IN
RELATION TO GRADUATES OF
U.S. MEDICAL SCHOOLS:
selected years 1939-40 through 1973-74

Year	Internships offered	Graduates of U.S. medical schools ¹	Internships offered per medical graduate
1939 - 40	6,684	5,089	1.3
1949 - 50	9,124	5,094	1.8
1954 - 55	11,048	6,861	1.6
1955 - 56	11,616	6,977	1.7
1956 - 57	11,895	6,845	1.7
1957 - 58	12,325	6,796	1.8
1958 - 59	12,469	6,861	1.8
1959 - 60	12,580	6,860	1.8
1960 - 61	12,547	7,081	1.8
1961 - 62	12,074	6,994	1.7
1962 - 63	12,024	7,168	1.7
1963 - 64	12,229	7,264	1.7
1964 - 65	12,728	7,336	1.7
1965 - 66	12,954	7,409	1.7
1966 - 67	13,569	7,574	1.8
1967 - 68	13,761	7,743	1.8
1968 - 69	14,112	7,973	1.8
1969 - 70	15,003	8,058	1.9
1970 - 71	15,354	8,367	1.8
1971 - 72	15,422	8,974	1.7
1972 - 73	13,650	9,551	1.4
1973 - 74	15,396	10,391	1.5

¹ For year ending in June before the intern year.

Source: 1940-1960 figures from William H. Stewart and Marion E. Altenderfer, *Health Manpower Source Book, Hospital House Staffs*, Public Health Service Publication No. 263, Section 13, Table 4. 1961-74 figures from *Journal of the American Medical Association*, Education Numbers.

Type of House Staff Position Over 21,950 foreign-trained physicians were in graduate medical education positions in American hospitals and universities in 1972-73, a ten-fold increase since 1950-51 (Table 25). Approximately 3,920 were interns, 14,440 were residents, and

another 3,590 were in "other" graduate training positions. The "other" category includes posts classified as research or teaching fellowships, clinical traineeships, and work leading toward specialization and possible specialty board certification.

This "other" category grew from 1,024 foreign medical graduates in 1962-63 to 4,106 in 1971-72, but dropped the following year to 3,595 foreign-trained physicians, representing 40 percent of all trainees in the category. The proportions of these FMGs are particularly high in colon and rectal surgery, general practice, anesthesiology, and general surgery. Some foreign medical graduate "trainees" are probably classified as "other" for reasons relating to program accreditation, e.g., a hospital may employ a "Fellow" in anesthesiology even without an approved residency training program (19). Some physicians in this category may also be working in nonpatient care activities which do not require physicians to have the ECFMG certificate.

Sex Of the 1,739 women in internship positions in 1972, over 52 percent were graduates of foreign medical schools. Similarly, of the 4,942 women in residencies, 53 percent were FMGs. Furthermore, in 1972, some 23 percent of the FMGs in internships were women, compared with 11 percent of the USMGs (including Canadians). For residents, the comparable figures were 18 percent for FMGs and 11 percent for USMGs (10).

The National Intern and Resident Matching Program (NIRMP) In 1951, the National Intern Matching Program was set up as a means of reducing the competition for interns among hospitals and of introducing some order into the selection process for prospective

interns. Under the guidance of the Council on Medical Education, the Association of American Medical Colleges, and various hospital organizations, the Matching Program developed a procedure and a set of rules by which hospitals and prospective interns could make their selection of, respectively, house staff and posts. In essence, the computer-based Program has as one of its chief advantages the fact that all participants will be "matched" (i.e., appointed) to the hospital highest on his confidential list of preferred hospitals which will accept him. Since 1968, the program has also been available for residents, and is now known as the National Intern and Resident Matching Program (10,

pp. 103-110). Since its inception, the NIRMP has brought more organization to the entire process of selecting house staff and positions; by providing a sophisticated clearing house function, medical students could henceforth become interns (and interns become residents) in a more orderly manner. There is no compulsion on hospitals (or, for that matter, on prospective house staffs) to use the matching program, but during the past 21 years, over 98 percent of hospitals with approved intern training programs have participated. The program matches over 9,000 participants a year, which represents the vast majority of U.S. medical school graduates in any given year. In 1972,

over 8,700 U.S. medical graduates participated, and almost 8,400 were matched. The NIRMP has not been used to the same extent by foreign medical graduates, although it is available to them. In 1972, for example, 584 FMGs participated in NIRMP (of at least 5,000 new foreign-trained physicians who entered house staff training) and 490 were matched (24, p. 107). Of the 200 Canadian graduates who participated, 165 were matched. It is anticipated, however, that the number of FMGs participating in 1973 and thereafter will rise significantly, because the regulations have been modified to make it easier for FMGs to participate (24, p. 106).

Table 25
FOREIGN MEDICAL GRADUATES IN GRADUATE TRAINING PROGRAMS IN
THE UNITED STATES,
1950-51 through 1972-73

Year ²	Interns		Residents		Other graduate trainees		Total foreign medical graduates in graduate training programs ¹	
	Number	Percent of filled positions	Number	Percent of filled positions	Number	Percent of filled positions	Number	Percent of filled positions
1950 - 51	722	10	1,350	9	N.A.	—	2,072	10
1951 - 52	1,116	14	2,233	14	N.A.	—	3,349	14
1952 - 53	1,353	18	3,035	18	N.A.	—	4,388	18
1953 - 54	1,787	22	3,802	20	N.A.	—	5,589	21
1954 - 55	1,761	19	3,275	16	N.A.	—	5,036	17
1955 - 56	1,859	19	4,174	19	N.A.	—	6,033	19
1956 - 57	1,988	20	4,753	21	N.A.	—	6,741	20
1957 - 58	2,079	20	5,543	22	N.A.	—	7,622	22
1958 - 59	2,315	22	6,042	23	N.A.	—	8,357	23
1959 - 60	2,545	25	6,912	15	N.A.	—	9,457	25
1960 - 61	1,753	19	8,182	29	N.A.	—	9,935	26
1961 - 62	1,273	16	7,723	26	N.A.	—	8,996	24
1962 - 63	1,669	19	7,062	24	1,024	35	9,755	24
1963 - 64	2,566	27	7,052	24	1,791	40	11,409	26
1964 - 65	2,821	28	8,153	26	1,925	39	12,899	28
1965 - 66	2,361	24	9,113	29	2,355	41	13,829	29
1966 - 67	2,793	27	9,505	30	2,566	41	14,864	31
1967 - 68	2,913	28	10,627	31	3,077	43	16,617	32
1968 - 69	3,270	31	11,231	32	4,046	50	18,547	35
1969 - 70	2,939	27	12,126	33	3,220	N.A.	18,285	N.A.
1970 - 71	3,339	29	12,968	33	3,331	43	19,638	33
1971 - 72	3,946	33	13,520	32	4,106	45	21,572	34
1972 - 73	3,924	35	14,440	32	3,595	40	21,959	34

¹ Excluding Canadians.

² ECFMG deadline imposed in 1960-61; amendments to Immigration and Nationality Act in 1965-66.
Source: Reference 22; Directory of Approved Internships and Residencies, selected years.

The matching program may also be one factor in the differential placement of U.S. and foreign-trained physicians (excluding Canadians) in affiliated and nonaffiliated institutions. Approved training programs, especially in university-affiliated hospitals, tend to be the more prestigious and one result of the NIRMP has been a more efficient system for distributing U.S. graduates to these preferred hospital programs. Internship placements run about 3:1 in favor of university-affiliated hospitals (25, pp. 20-21). Interns in these hospitals are also, one might assume, more likely than those in nonaffiliated hospitals to take residency posts in the university setting. For example, foreign medical graduates represented only 29 percent of house staff in affiliated hospitals in 1972, compared with 64 percent of the house staff in nonaffiliated hospitals (Table 26).

Table 26
FOREIGN MEDICAL GRADUATES SERVING
AS INTERNS AND RESIDENTS IN
AFFILIATED AND NONAFFILIATED HOSPITALS
IN THE UNITED STATES, BY
SIZE OF HOSPITAL:
1972

Affiliation and size of hospital	Total filled positions	Filled by foreign medical graduates ¹	Percent filled by foreign medical graduates
Grand total	56,021	18,364	33
Affiliated hospitals:			
Total	50,350	14,741	29
Combined hospitals ²	18,651	3,954	21
Less than 200 beds	2,503	681	27
200 - 299	1,653	691	42
300 - 499	8,192	3,262	40
500 and over	19,349	6,152	32
Nonaffiliated hospitals:			
Total	5,671	3,623	64
Combined hospitals ²	403	208	52
Less than 200 beds	609	319	52
200 - 299	833	671	81
300 - 499	1,834	1,357	74
500 and over	1,992	1,068	54

¹ Excluding Canadians.

² Includes programs using the resources of two or more hospitals.

Source: Reference 22.

Affiliated and Nonaffiliated Hospitals

The great majority of internships and residencies now being offered are in hospitals which have entered into affiliation agreements with medical schools. Insofar as nonaffiliated programs continue to exist, foreign-trained physicians will play a much more substantial role than U.S. graduates in them (Table 26). Over 3,620 foreign-trained physicians were working as interns and residents in nonaffiliated hospitals in 1972, compared with only 2,040 U.S. or Canadian graduates. The 1950s saw a marked tendency for foreign house staff to receive appointments in hospitals not affiliated with university medical schools. By 1960, nearly twice as many foreign physicians were in nonaffiliated as in affiliated hospitals (26). This has been completely reversed in the intervening decade, however. In 1972, for example, over five times as many foreign-trained residents were in affiliated hospitals compared with nonaffiliated hospitals (Table 27). Only 16 percent of all foreign-trained residents were working in nonaffiliated hospitals in 1972, down from a high of 63 percent in 1964.

Because of the parallel shift by hospitals from nonaffiliated to affiliated status, no conclusion should be drawn from changes in the proportions of FMGs in affiliated versus nonaffiliated programs for the various years (as given in Table 27). More refined analysis is needed to show whether the percentage of foreign-trained house staff in affiliated hospitals has increased over and above what can be accounted for by the change in hospital affiliation status.

Regardless of the hospital's affiliation status, the number of foreign medical graduates in hospitals as a proportion of the total house staff does not show a consistent pattern. Some hospitals have house staffs composed entirely or predominantly of foreign physicians. Others have few or none. A statistical review of affiliated and nonaffiliated hospitals by the AMA in 1967 showed more than 300 hospitals (31 percent of the hospitals reporting) in which foreign medical graduates comprised more than 75 percent of the residents (Table 28). Were the figures to be broken down into affiliated and nonaffiliated hospitals, the proportion of FMG house staff for the nonaffiliated hospitals alone would undoubtedly be higher.

Table 27
NUMBER OF FOREIGN MEDICAL GRADUATES¹
SERVING AS RESIDENTS IN
AFFILIATED AND NONAFFILIATED HOSPITALS
IN THE UNITED STATES:
1963-64 — 1972-73

Year	FMG Residents in All Hospitals		Affiliated hospitals		Nonaffiliated hospitals	
	Number	Percent	Number	Percent	Number	Percent
1963 - 64	7,052	100	2,910	41	4,142	59
1964 - 65	8,140	100	3,046	37	5,094	63
1965 - 66	9,113	100	4,565	50	4,548	50
1966 - 67	9,483	100	4,911	52	4,572	48
1967 - 68	10,605	100	6,292	59	4,313	41
1968 - 69	11,201	100	7,217	64	3,984	36
1969 - 70	N.A.	—	N.A.	—	N.A.	—
1970 - 71	12,943	100	9,751	75	3,192	25
1971 - 72	13,520	100	10,870	80	2,650	20
1972 - 73	14,440	100	12,202	84	2,238	16

¹ Excluding Canadians.

Source: *Directory of Approved Internships and Residencies*, selected years.

Specialty One point relating to affiliated and nonaffiliated programs is the differential distribution of FMGs by specialty. As might be expected, foreign-trained physicians play a relatively large role in hospital service specialties in short supply in nonaffiliated hospitals, and also in specialties devoted to general or primary care. In 1972, for example, over 70 percent of the residency positions in nonaffiliated hospitals in general practice, pathology, neurology, and anesthesiology were filled by foreign-trained physicians; at least 60 percent of the residents in nonaffiliated hospitals in obstetrics and gynecology, general surgery, colon and rectal surgery, pediatrics, psychiatry, and internal medicine were FMGs. In every case, the proportion of foreign medical graduates in these specialties was much lower in university-affiliated programs (Appendix Table 6). The highest proportion of FMGs in filled positions in affiliated hospitals were in general practice (69 percent), colon and rectal surgery (64 percent), physical medicine (62 percent), anesthesiology (57 percent), and pathology (54 percent). The proportion of FMGs in residencies in affiliated hospitals was higher than in nonaffiliated hospitals in otolaryngology and radiology.

Table 28
FOREIGN MEDICAL GRADUATES¹ AS PERCENTAGE
OF HOUSE STAFFS IN
INDIVIDUAL HOSPITALS:
1967

	Internships		Residencies	
	Number of Hospitals	Percent	Number of Hospitals	Percent
Total reporting	704	100	990	100
Hospitals with 0-25% FMGs	368	52	423	43
Hospitals with 26-50% FMGs	49	7	151	15
Hospitals with 51-75% FMGs	33	5	105	11
Hospitals with 76-100% FMGs	254	36	311	31

¹ Excluding Canadians.

Source: *Directory of Approved Internships and Residencies* 1968-69, Table 14, p. 26. Chicago: American Medical Association, 1968.

Table 29
FOREIGN MEDICAL GRADUATES AS PERCENT OF ALL RESIDENTS, BY SPECIALTY
1963-64 — 1972-73

Percentage of foreign medical graduates ¹ in filled residency positions ²

Specialty	1963-64	1964-65	1965-66	1966-67	1967-68	1968-69	1969-70	1970-71	1971-72	1972-73
Total number of foreign medical graduates in residencies	7,062	8,140	9,113	9,483	10,605	11,201	12,943	13,520	14,440	
Anesthesiology	38	39	46	50	50	50	52	54	58	
Child psychiatry	17	19	23	22	21	19	24	25	27	
Colon and rectal surgery	50	47	64	67	61	55	55	44	65	
Dermatology	11	13	12	11	10	9	12	8	9	
Family practice	—	—	—	—	—	—	11	11	12	
General practice	52	63	66	67	65	55	69	70	79	
Internal medicine	23	25	28	30	34	35	35	35	35	
Neurological surgery	16	18	17	17	21	22	24	22	20	
Neurology	22	24	24	27	28	26	29	30	27	
Obstetrics and gynecology	22	25	27	30	33	37	40	40	39	
Ophthalmology	8	10	9	9	8	7	8	8	8	
Orthopedic surgery	11	12	13	13	15	12	11	9	11	
Otolaryngology	11	14	12	12	11	12	14	16	17	
Pathology	34	37	40	42	46	48	54	55	56	
Pediatrics	33	37	41	39	39	42	42	38	37	
Pediatric allergy	26	22	35	31	25	22	38	17	23	
Pediatric cardiology	36	49	54	52	65	53	54	39	39	
Physical medicine	30	35	44	44	50	40	62	59	61	
Plastic surgery	13	27	21	16	24	22	20	21	24	
Psychiatry	24	25	27	27	29	29	28	27	27	
Radiology	17	17	18	18	20	20	19	21	27	
Surgery	27	30	32	35	36	37	39	38	38	
Thoracic surgery	30	37	38	38	43	44	39	43	36	
Urology	16	19	23	24	24	25	28	25	22	
Total	24	26	29	30	32	32	33	32	32	

¹ Excluding Canadians.

² This table includes residents in hospital positions only. In 1972, for example, there were another 31 foreign graduates in residencies outside hospitals, notably in General Preventive Medicine. 1969 figures are not available.

Source: Graduate Medical Education, *Journal of the American Medical Association*, or *Directory of Approved Internships and Residencies*, selected years.

The pattern of residencies by specialty also has shown consistent differences over the last decade in the relative distributions of U.S. and foreign-trained graduates, taking all types of hospitals together (Table 29). FMGs as hospital residents appear to be concentrated in certain specialties. The reasons for this are complex, and appear to center on such factors as residual placement of FMGs in hospital positions (once all possible vacancies have been filled by USMGs) and special requirements for Board certification (27, p. 39).

This analysis is based on an implied comparison of the representation of FMG residents in specialties compared with the representation of U.S. residents in those same specialties. The proportion of FMG residents in specialties out of the total number of FMG residents indicates that the majority of FMGs in fact elect graduate training in one of the five major specialties (Table 30). Of 14,100 FMG residents (including Canadians) in 1970, over 7,400 were in internal medicine, general surgery, pediatrics, obstetrics and gynecology,

or psychiatry. Thus, although FMGs fill residency vacancies in specialties not taken by USMGs, many FMGs are still obtaining residency training in the major specialties preferred by USMGs.

Table 30
TOTAL RESIDENTS AND FOREIGN MEDICAL
GRADUATES IN RESIDENCIES, BY
SPECIALTY:

Specialty	Total residents	Foreign medical graduates ¹ in residencies	
		Number	Percent of total residents
Total	39,779	14,123	36
General practice	876	296	34
Allergy	61	14	23
Cardiovascular diseases	568	276	49
Dermatology	556	85	15
Gastroenterology	221	112	51
Internal medicine	6,568	2,050	31
Pediatrics	2,567	1,052	41
Pediatric allergy	43	19	44
Pediatric cardiology	68	41	60
Pulmonary disease	201	107	53
General surgery	5,899	2,287	39
Neurological surgery	520	145	28
Obstetrics and gynecology	2,384	1,004	42
Ophthalmology	1,334	146	11
Orthopedic surgery	1,834	264	14
Otolaryngology	814	153	19
Plastic surgery	256	72	28
Colon and rectal surgery	22	14	64
Thoracic surgery	199	94	47
Urology	832	227	27
Aviation medicine	74	6	8
Anesthesiology	1,408	758	54
Child psychiatry	315	98	31
Diagnostic roentgenology	516	87	17
Forensic pathology	10	3	30
Neurology	696	222	32
Occupational medicine	16	2	12
Psychiatry	3,278	1,015	31
Pathology	2,103	1,083	51
General preventive medicine	44	3	7
Physical medicine and rehabilitation	236	157	67
Public health	96	6	6
Radiology	2,057	480	23
Therapeutic radiology	203	58	29
Other	2,904	1,687	58
Unspecified			

¹ Including Canadians.

Source: References 1 and 19.

Geographical Area Foreign medical graduates in graduate medical education are not distributed evenly by geographic location. Of the 14,440 residency positions filled in 1972 by FMGs (excluding Canadians), 5,835 (or 40 percent) were in the Middle Atlantic States of New York, New Jersey, and Pennsylvania (Appendix Table 7). The Middle Atlantic States also lead in the number of positions offered (13,057 of 51,115, or 26 percent) and positions filled (11,882 of 44,858, or 26 percent).

New York leads all other States in numbers of foreign-trained residents as it does in the number of foreign-trained physicians as a whole. In terms of the relative proportion of foreign-trained residents, however, New Jersey is the outstanding State; in 1972, foreign medical graduates constituted 78 percent of all hospital residents.

Among other "high" States on percentage of FMGs in filled residency positions were Delaware, Rhode Island, Illinois, and West Virginia. In these States, hospitals are substantially dependent on foreign medical graduates. At the other end of the scale are States with relatively few foreign-trained residents compared with the number of American and Canadian graduates, including Arkansas, Colorado, Mississippi, and Utah. Internships tend to follow a similar pattern, and in some regions the differences are even more marked. The percentage of foreign graduates in filled internship positions was higher than the percentage in filled residency positions in the New England, Middle Atlantic, East North Central, South Atlantic, and Mountain States (22, pp. 925, 931).

Country of Medical Education Among foreign-trained physicians serving in U.S. graduate training programs in 1972, about one-third were educated in India (18 percent) and in the Philippines (14 percent). Korea, Taiwan, Thailand, Iran, and Pakistan together contributed another 23 percent. At least 2 percent of the total number of foreign trainees were educated in each of the following countries: Spain, Mexico, Italy, Argentina, and Egypt (UAR). Foreign graduates from Asia represented the largest group (64 percent of those in training programs); 16 percent were educated in the Americas; 16 percent in Europe; 3 percent in Africa; and under 1 percent in Oceania (22, p. 939). The reader is reminded that graduates of Canadian schools are not included in these AMA tabulations.

Performance of FMGs

As the FMG population in the United States has grown, so has interest in the group's medical proficiency. Despite this interest, few direct measures of performance have been developed which indicate, under controlled conditions, the relative medical ability of USMGs and FMGs. A number of statistics are available from which reasonable, albeit generalized, inferences concerning the relative performance of U.S. and foreign-trained physicians have been drawn. Most of these data refer only to performance on examinations and should not be extrapolated to expected performance in the clinical setting. Other information is available on specialty board certification and on more subjective evaluations.

ECFMG Performance One basis for analyzing FMG performance is the examination of the Educational Council for Foreign Medical Graduates (ECFMG). By 1973, over 178,320 foreign-trained physicians had taken a total of 315,885 examinations, and some 119,800 had eventually passed it (Table 31). As noted earlier, the medical part of the examination is based on questions from Parts I and II of the National Board of Medical Examiners, and thus is directly related to material covered by U.S. medical students or recently graduated physicians. FMGs sitting for the examination, however, have graduated from medical school over a wide range of years. The actual distribution of FMG test scores and expected distribution of USMG test scores for the February 1969 examination are shown in Table 32. Scores ranging from 75 (passing) to 90+ included only 38 percent of the FMGs but would take in approximately 99 percent of the U.S. medical students. Furthermore, FMG scores tend to be concentrated at the minimal pass level of 75; raising the standard to 80, for example (27), would eliminate, at least at the outset, from one-half to two-thirds of those FMGs who have passed, compared with only about one-fifth of the expected U.S. distribution on the same examination (Table 32). It should be emphasized that these figures, although suggestive of a marked differential between foreign and U.S. graduates, are not a direct measure of relative performance. The AMA has taken the position that "recipients of such certification have medical knowledge at least comparable to the minimum expected of graduates of approved medical schools in the United States and Canada" (28).

Each year about 38 percent of the ECFMG candidates score 75 or more and thereby become eligible for certification, although the percent passing reached its

Table 31
EXAMINATIONS GIVEN BY THE
EDUCATIONAL COUNCIL FOR
FOREIGN MEDICAL GRADUATES:
1958-73

Year	First exami- nation	Repeat exami- nation	Total exami- nations	Number passing	Percent passing
Total	178,325	137,560	315,885	119,802	38
1958	1,094	48	1,142	570	50
1959	4,477	363	4,840	2,139	44
1960	11,301	3,467	14,768	5,773	39
1961	8,204	6,018	14,222	5,381	38
1962	8,906	5,629	14,535	6,054	42
1963	11,391	7,739	19,130	6,043	32
1964	9,378	9,133	18,511	6,820	37
1965	9,204	9,133	18,337	7,724	42
1966	10,765	8,223	18,988	7,842	41
1967	11,777	7,411	19,188	8,820	46
1968	11,975	7,573	19,548	7,774	40
1969	12,447	10,151	22,598	8,127	36
1970	16,631	13,319	29,950	11,916	40
1971	16,525	14,508	31,033	9,693	31
1972	15,556	16,516	32,072	12,837	40
1973	18,694	18,329	37,023	12,289	33

Source: Annual Report, 1972. Philadelphia: Educational Council for Foreign Medical Graduates, Federation of State Medical Boards of the United States, Inc., Reports, February 1974.

lowest point ever in 1971 (Table 31). This overall average obscures the wide variation in pass rates among countries and medical schools within countries. Since 1968, the ECFMG has recorded the total number of FMGs from each medical school who sit for the examination and the number who pass or fail.

Appendix Table 8 gives the pass rates on the ECFMG examination by country of medical education for three recent years. A high percentage of FMGs educated in English-speaking countries, where clinical methods of medical education are used, were successful on the examination. FMGs trained in developed countries other than English-speaking ones were also more successful, although Eastern European countries tended to fall somewhat low on the scale. FMGs trained in medical schools located in developing countries where teaching was in a language other than English are notably less successful.

Table 32
PERCENTAGE DISTRIBUTION OF
PERSONS TAKING ECFMG EXAMINATION,
BY RANGE OF SCORES AND
COUNTRY OF GRADUATION:
1969

Range of scores	Actual distribution of foreign medical graduates		Expected distribution of graduates of U.S. medical schools	
	Percent	Cumulative	Percent	Cumulative
90 or higher	0	0	4.6	4.6
85 to 89	2.1	2.1	28.9	33.5
80 to 84	10.2	12.3	46.1	79.6
75 to 79 ¹	25.7	38.0	19.5	99.1
70 to 74	27.2	65.2	0.9	100.0
65 to 69	24.2	89.4	0	—
60 to 64	9.0	98.4	0	—
Below 60	1.6	100.0	0	—

¹ Passing score is 75.

Source: Reference 17.

A special count is made of U.S. citizens sitting for the examination in those foreign countries where they are enrolled in medical school. The U.S.-born FMGs do not appear to be any more successful on the ECFMG examination than the FMG group as a whole (7). For example, on the 1972 examination, the entire group had a pass rate of 40 percent; U.S. citizens alone had a rate of 36 percent. (Of those U.S.-born FMGs educated in English-speaking countries, however, 73 percent passed in 1972, although this is based on only a very small number of examinations.) The pass rates for all candidates in several selected countries where relatively high numbers of U.S. citizens are educated vary over a wide range, e.g., Spain, 23 percent; Mexico, 28 percent; Italy, 34 percent; Belgium, 59 percent; and Switzerland, 82 percent.

A number of caveats must be recognized in interpreting these figures. Aptitudes and medical qualifications of graduates from an individual foreign medical school vary considerably, as does the percentage of the graduating classes from foreign medical schools that sit for the examination. Furthermore, it is not always known whether the best qualified graduates elect (or are permitted) to sit. National policies and the entire professional and political environment can have a significant effect in this area. Finally, successful performance on the examination depends on the ability to cope with both the English language and objective (multiple-choice) questions.

Licensure Table 33 gives a clear indication of how the percentage of new licentiates from foreign schools has risen over the years. Two decades ago, FMGs represented only 10 percent of all new licentiates; by 1972, this percentage has more than quadrupled (to 46 percent), while the total number of new licentiates has doubled in that same interval. U.S.-born FMGs as new licentiates have numbered between 468 and 198 in the 16 years for which statistics are available. The proportion of U.S.-born FMGs, out of the total number of newly-licensed FMGs representing additions to the medical profession, has steadily decreased, however, from a high of 31 percent in 1961 to 13 percent in 1967 and 4 percent in 1972.

Table 33
NEW LICENTIATES REPRESENTING
ADDITIONS TO THE MEDICAL PROFESSION,
BY COUNTRY OF GRADUATION:
1950-72

New licentiates representing additions
to medical professions

Year	Total	U.S. and Canadian	Foreign medical graduates		Foreign medical graduates as percent of total
			Total	U.S. born	
1950	6,002	5,694	308	N.A.	5.1
1951	6,273	5,823	450	N.A.	7.2
1952	6,885	6,316	569	N.A.	8.3
1953	7,276	6,591	685	N.A.	9.4
1954	7,917	7,145	772	N.A.	9.8
1955	7,737	6,830	907	N.A.	11.7
1956	7,463	6,611	852	N.A.	11.4
1957	7,455	6,441	1,014	212	13.6
1958	7,809	6,643	1,166	284	14.9
1959	8,269	6,643	1,626	366	19.7
1960	8,030	6,611	1,419	386	17.7
1961	8,023	6,443	1,580	468	19.7
1962	8,005	6,648	1,357	201	17.0
1963	8,283	6,832	1,451	395	17.5
1964	7,911	6,605	1,306	200	16.5
1965	9,147	7,619	1,528	411	16.7
1966	8,851	7,217	1,634	252	18.5
1967	9,424	7,267	2,157	279	22.9
1968	9,766	7,581	2,185	235	22.4
1969	9,978	7,671	2,307	179	23.1
1970	11,032	8,016	3,016	198	27.3
1971	12,257	7,943	4,314	210	35.2
1972	14,476	7,815	6,661	240	46.0

Source: References 8 and 22.

Work by Knobel indicates that FMGs educated in the more highly developed countries are more likely to sit for State licensure examinations than are FMGs educated in most of the developing world (29). This used to be especially true with regard to FMGs from the Far East, in that a substantial fraction of that subgroup did not elect or were not able to sit. This is apparently changing, however, because the number of licensed physicians from Korea, the Philippines, and Thailand (among the several Far Eastern countries) is beginning to increase dramatically (11, p. 16).

The discrepancy between the requirements for licensure which must be met by the FMG and USMG should be emphasized (30). Over half the States have special requirements for FMGs over and above the usual (but not universal) procedures such as written examinations, certification by the ECFMG, and internship training; and these various prerequisites and regulations differ widely among the States. In 1972, six States still listed U.S. citizenship as a requirement for permanent licensure of physicians trained in countries outside the United States or Canada, six required an immigrant visa, and another 26 required a declaration of intent to become a U.S. citizen (8, p. 55). Furthermore, the requirements may differ depending on whether the FMG is applying for temporary or permanent licensure. The practical result of all these special requirements has been to restrict the geographic mobility of the FMG in comparison with his USMG counterpart, or at least of that portion of the FMG group which desires to be licensed.

The State licensure examination is the first point at which FMGs and USMGs are tested with the same instrument. Between 1964 and 1972, over 49,900 State licensure examinations were administered to FMGs (Table 34, Appendix Table 9), many for the second or third time. Over 32,000 successful examinations were recorded. This constitutes an overall pass rate of 64 percent, which is considerably lower than the USMG pass rate (about 94 percent) for the same period. Use of the FLEX examination among virtually all States in the Union has made it possible to provide a basis of comparison of performance almost nationwide (31). A recent report, however, indicates that FMGs now comprise close to 75 percent of the candidates for licensure in States using FLEX (31, p. 53). Furthermore, FMGs taking the complete FLEX examination between June 1968 and December 1972 are reported to have had a pass rate of just under 50 percent, compared to a pass rate of about 85 percent for USMGs (31, p. 53).

Statistics show that, as aggregate populations, USMGs perform significantly better on the licensure examinations than FMGs, but the aggregate pass rates gloss over a conglomeration of different licensing prerequisites, regulations, procedures, and pass rates among the various States. Appendix Table 9 presents data for 1964 through 1972 on State licensure examinations taken by FMGs, showing the total number of examinations taken (by State) and the number passed. The percent pass rates are given for each year; summary data for the entire period are in Table 34. It would appear that the pass rate for FMGs has not changed much in the interval, having been 68 percent in 1964 and 64 percent in 1972. Pass percentages from year to year in most States tended to be fairly consistent (with some exceptions, including California, the District of Columbia, Indiana, Massachusetts, New Mexico, North Carolina, and West Virginia). States giving the largest number of examinations include New York, Pennsylvania, Florida, Illinois, New Jersey, Virginia, and California. Each of these States passed (and presumably licensed) over 1,500 FMGs between 1964 and 1972 (and New York and Pennsylvania presumably over 4,000), but their pass rate differed considerably (ranging, for example, from 50 percent in Illinois to 90 percent in Florida). These wide variations in pass rates are fairly constant throughout the State listing and are not completely explained by the quality of the candidates sitting in any one State or by the number of FMGs sitting for the examination.

Table 35 gives a more detailed review of the 1972 licensure statistics, showing that U.S. and Canadian graduates fared better on licensure examinations than foreign graduates. In the aggregate, 89 percent of the USMGs passed State board examinations in 1972, compared with 86 percent of the Canadian graduates and 64 percent of the other FMGs. The only exceptions to this were the following States, in which FMGs did roughly as well as, or better than, the USMG group: Georgia, Hawaii, Illinois, Michigan, New Jersey, Oklahoma, South Dakota, Tennessee, Wisconsin, Wyoming, and Puerto Rico.

Certain States administered examinations to far greater numbers of FMGs than USMGs, the most notable being the District of Columbia, Illinois, New Jersey, Pennsylvania, and Virginia. Four States administered licensure examinations only to FMGs: Alaska, Connecticut, New Hampshire, and North Dakota. Because of a reporting discrepancy, data on New York for 1972 are missing, but over recent years, that State has also administered more examinations to FMGs than USMGs.

Table 34
FOREIGN MEDICAL GRADUATES¹
EXAMINED FOR LICENSURE, BY STATE:
1964-72

1964-72 examinations				1964-72 examinations			
State	Total	Pass	Percent	State	Total	Pass	Percent
Total ²	49,945	32,031	64	Nebraska	22	15	68
Alabama	26	20	77	Nevada	14	8	57
Alaska	37	32	86	New Hampshire	448	332	74
Arizona	253	176	70	New Jersey	2,707	1,753	65
Arkansas	25	18	72	New Mexico	217	120	55
California	2,641	1,596	60	New York ²	7,292	3,432	47
Colorado	91	81	89	North Carolina	315	194	62
Connecticut	707	468	66	North Dakota	245	214	87
Delaware	245	167	68	Ohio	1,594	946	59
District of Columbia	1,044	878	84	Oklahoma	59	52	88
Florida	3,584	2,315	65	Oregon	57	45	79
Georgia	403	388	96	Pennsylvania	4,888	4,182	86
Hawaii	165	121	73	Rhode Island	215	156	73
Idaho	12	11	92	South Carolina	26	21	81
Illinois	4,206	2,111	50	South Dakota	75	67	89
Indiana	1,493	729	49	Tennessee	112	112	100
Iowa	260	243	93	Texas	960	772	80
Kansas	266	237	89	Utah	65	55	85
Kentucky	396	323	82	Vermont	1,341	735	55
Louisiana	238	178	75	Virginia	3,259	1,709	52
Maine	1,187	691	58	Washington	664	550	83
Maryland	2,199	1,299	59	West Virginia	435	232	53
Massachusetts	922	552	60	Wisconsin	607	534	88
Michigan	1,274	1,033	81	Wyoming	14	7	50
Minnesota ²	266	205	77	Puerto Rico	677	607	90
Mississippi	109	95	87	Virgin Islands			
Missouri	1,541	1,170	76	Canal Zone			
Montana	57	44	77				

¹ Excluding Canadians.

² Data were not given or were incomplete for 1972, so figures include only 1964-71. The total includes 1964-71 data for New York and Minnesota and 1964-72 for all other States.

Source: Appendix Table 8.

Table 35
 PHYSICIANS EXAMINED FOR LICENSURE, BY STATE OF EXAMINATION AND
 COUNTRY OF GRADUATION:
 1972

State	U.S. medical graduates			Foreign medical graduates ¹			Canadian foreign medical graduates		
	Total	Pass	Percent	Total	Pass	Percent	Total	Pass	Percent
Total	4,840	4,260	89	9,113	5,815	64	105	90	86
Alabama	6	6	100	2	0	0	0	0	—
Alaska	0	0	—	4	3	75	0	0	—
Arizona	13	13	100	40	22	55	0	0	—
Arkansas	109	102	94	14	10	71	0	0	—
California	210	195	93	661	321	49	39	35	90
Colorado	4	4	100	3	2	67	1	1	100
Connecticut	0	0	—	16	8	50	0	0	—
Delaware	7	6	86	96	60	63	0	0	—
District of Columbia	14	14	100	215	215	100	1	1	100
Florida	998	688	69	1,077	513	48	19	12	63
Georgia	422	422	100	155	155	100	0	0	—
Hawaii	26	18	69	30	20	67	3	3	100
Idaho	2	1	50	2	2	100	0	0	—
Illinois	26	16	62	1,288	780	61	7	6	86
Indiana	209	208	99	178	55	31	0	0	—
Iowa	261	261	100	84	74	88	3	3	100
Kansas	95	93	98	96	83	86	1	1	100
Kentucky	148	148	100	63	63	100	1	1	100
Louisiana	267	239	90	54	32	59	1	1	100
Maine	1	1	100	90	90	100	0	0	—
Maryland	88	81	92	365	186	51	1	1	100
Massachusetts	5	5	100	214	135	63	2	2	100
Michigan	120	118	98	247	247	100	13	13	100
Minnesota ²	18	18	100	0	0	—	0	0	—
Mississippi	106	103	97	9	6	67	1	1	100
Missouri	199	167	84	461	278	60	0	0	—
Montana	3	3	100	13	2	15	0	0	—
Nebraska	98	91	93	9	5	56	0	0	—
Nevada	1	1	100	8	4	50	0	0	—
New Hampshire	0	0	—	23	15	65	0	0	—
New Jersey	3	3	100	253	253	100	0	0	—
New Mexico	6	5	83	51	32	63	0	0	—
New York ³	0	0	—	0	0	—	0	0	—
North Carolina	147	140	95	102	53	52	1	1	100
North Dakota	0	0	—	80	70	88	0	0	—
Ohio	206	190	92	472	248	53	1	1	100
Oklahoma	70	70	100	17	17	100	1	1	100
Oregon	5	2	40	8	2	25	0	0	—
Pennsylvania	18	10	56	844	634	75	2	1	50

(Continued)

Table 35 (Continued)

State	U.S. medical graduates			Foreign medical graduates ¹			Canadian foreign medical graduates		
	Total	Pass	Percent	Total	Pass	Percent	Total	Pass	Percent
Rhode Island	1	1	100	21	18	86	0	0	—
South Carolina	21	21	100	0	0	—	1	1	100
South Dakota	16	16	100	20	19	95	0	0	—
Tennessee	197	196	99	53	53	100	0	0	—
Texas	407	352	86	159	100	63	1	1	100
Utah	10	9	90	3	2	67	0	0	—
Vermont	4	4	100	329	180	55	0	0	—
Virginia	92	89	97	826	455	55	0	0	—
Washington	8	7	88	71	65	92	4	3	75
West Virginia	30	25	83	96	45	47	0	0	—
Wisconsin	56	55	98	68	65	96	0	0	—
Wyoming	1	1	100	2	2	100	0	0	—
Puerto Rico	44	42	95	121	116	96	1	0	—
Guam									
Canal Zone									

¹ Excluding Canadians.² Incomplete - summary report only.³ Only totals given for New York. Total = 2,270, Pass = 895, Percent = 39.4.

Source: Reference 8.

Results on State licensure examinations in 1972 also vary by country and region of origin (in this case medical education), as shown in Table 36 and Appendix Table 10. The Americas (excluding Canada) have the lowest pass rate (59 percent); Oceania (in this case just Australia and New Zealand) the highest (90 percent). Europe, Asia, and Africa have rates of 71, 66, and 64 percent, respectively. These overall pass rates by region obscure wide variations among the several countries within each region, however (Appendix Table 10). The most notable distinction among the various FMG populations is that those educated in English-speaking countries have a pass rate materially superior to that of the other groups. (Earlier research by John Kosa had also shown that FMGs from English-speaking countries acquired medical credentials at rates closer to that of USMGs than did FMGs from non-English-speaking countries [32]). The country-by-country breakdown lends credence to the statement above that FMGs trained in the English-speaking countries do much better

than the norm on these examinations. On the other hand, those foreign countries with large enrollments of U.S. citizens in medical schools (e.g., Switzerland, Mexico, or Italy) do not on the whole have a pass rate superior to the overall norm.

Table 36
FOREIGN MEDICAL GRADUATES
EXAMINED FOR LICENSURE, BY
REGION OF GRADUATION:
1972

Region of graduation	Total examinations	Passed	Percent passed
Total	9,113	5,817	64
Europe	1,394	916	66
Americas	1,472	863	59
Asia	5,955	3,824	64
Africa	250	174	70
Oceania	42	38	90

Source: Appendix Table 10.

Table 37
FOREIGN MEDICAL GRADUATES IN
THE UNITED STATES BY COUNTRY OF
GRADUATION AND SPECIALTY BOARD
CERTIFICATION:
1970

Country of graduation	Total foreign medical ¹ graduates	Board certified	Percent Percent	Country of graduation	Total foreign medical ¹ graduates	Board certified	Percent Percent
Total	57,217	9,247	16	Panama	23	1	4
Europe	24,756	5,444	22	Paraguay	76	6	8
Austria	1,698	417	25	Peru	618	80	13
Belgium	511	108	21	Surinam	2	0	—
Bulgaria	49	9	18	Uruguay	46	5	11
Czechoslovakia	654	95	15	Venezuela	133	4	3
Denmark	82	22	27				
East Germany	745	163	22	Asia	21,002	2,257	11
Finland	31	6	19	Afghanistan	19	1	5
France	685	186	27	Burma	98	6	6
Germany	3,502	797	23	Ceylon	93	1	1
Greece	813	177	22	China	589	197	33
Hungary	862	233	27	Hong Kong	105	19	18
Iceland	42	5	12	India	3,957	363	9
Ireland	924	224	24	Indonesia	89	0	—
Italy	3,208	621	19	Iran	1,631	284	17
Malta	6	0	—	Iraq	188	40	21
Netherlands	726	220	30	Israel	214	34	16
Norway	44	21	48	Japan	882	97	11
Poland	602	74	12	Lebanon	615	205	33
Portugal	107	25	23	Malaysia	1	0	—
Romania	317	49	15	North Korea	5	1	20
Spain	1,801	197	11	North Vietnam	3	0	—
Sweden	54	9	17	Pakistan	784	65	8
Switzerland	2,510	784	31	Philippines	7,352	586	8
Turkey	866	124	14	Singapore	23	2	9
USSR	871	90	10	South Korea	2,095	176	8
United Kingdom	2,641	728	28	South Vietnam	12	0	—
Yugoslavia	405	60	15	Syria	173	18	10
				Taiwan	976	84	9
Americas	9,929	1,231	12	Thailand	1,098	78	7
Argentina	1,313	208	16				
Bolivia	146	10	7	Africa	1,126	253	22
Brazil	377	52	14	Algeria	1	0	—
Chile	176	15	9	Congo (Kinshasa)	1	0	—
Colombia	952	145	15	Egypt (UAR)	732	144	20
Costa Rica	11	0	—	Ethiopia	1	0	—
Cuba	2,757	345	13	Nigeria	24	0	—
Dominican Republic	629	60	10	Rhodesia	1	0	—
Ecuador	147	17	12	Senegal	1	0	—
El Salvador	91	2	2	South Africa	356	109	31
Guatemala	109	15	14	Sudan	2	0	—
Haiti	329	50	15	Uganda	7	0	—
Honduras	49	3	6				
Jamaica	46	5	11	Oceania	404	62	15
Mexico	1,821	199	11	Australia	325	48	15
Nicaragua	78	9	12	New Zealand	79	14	18

¹ Excluding Canadians.
Source: Reference 1.

Specialty Board Certification FMGs have been significantly less successful in qualifying for specialty board certification than their USMG peers. How much this is an indication of relative medical proficiency and how much an artifact of specialty board examination structure and requirements is not clear. The process of certification by American specialty boards is somewhat complex. Each of the 22 nationally recognized boards operates autonomously and sets its own standards, procedures, and requirements. These requirements may and usually do include the M.D. degree (or equivalent), a specified number of years of postgraduate training and other experience, a written and an oral examination, and (sometimes) citizenship. Although the policies of specialty boards have become more liberal with respect to FMGs in recent years, it should be recognized that the lengthy training and practical experience requirements probably reduced the number of FMGs becoming board certified in the past.

In any case, 16 percent of all FMGs (excluding Canadians) were certified by specialty boards as of 1970 (Table 37), compared to 41 percent of all USMGs (1, p. 11). The proportions of FMGs from Europe and Africa (22 percent each) holding specialty board certification were higher than for all FMGs; the proportions of FMGs from Oceania, the Americas, and Asia were lower (15, 12, and 11 percent, respectively). These regional percentages mask wide variations among the countries, however, as can be seen in Table 37. When just those presumed eligible for certification are compared (i.e., those in activities other than training), 23 percent of the FMGs and 43 percent of the USMGs were board certified as of 1970. This represents an increase in the proportion of both FMGs (excluding Canadians) (21 percent) and USMGs (39 percent) who were board certified as of 1967 (33, pp. 15, 24-25).

Board certification is not spread evenly throughout the FMG population, as Table 37 indicates. Graduates trained in medical schools of English-speaking countries (Australia, New Zealand, South Africa, and the United Kingdom) show a much higher percentage of board certification (26 percent) than the FMG population as a whole (16 percent) or the non-English-speaking countries alone (15.5 percent) (Table 38). This group constitutes only a small fraction (6 percent) of the total FMG population, however, and of the FMG population that is board certified (10 percent).

With regard to specialty certification, it is important to note that three of every ten FMGs are still interns or residents. Under most circumstances, these FMGs would thus not be eligible for specialty board certification,

since most boards require completion of residency training and a number of years of specialty experience before candidates are considered eligible for certification. Eligibility is thus somewhat a function of age. As noted earlier, a higher percent of FMGs than USMGs are in the younger age groups; they have come to the U.S. early in their careers, are often still in the training phase of their careers, and have not been in the United States long enough to be able to sit for the examination.

Table 38
FOREIGN MEDICAL GRADUATES
IN THE UNITED STATES, BY
LANGUAGE GROUP AND SPECIALTY
BOARD CERTIFICATION: 1970

Language group	Total foreign medical graduates ¹	Board certified	Percent
Total	57,217	9,247	16
English speaking	3,401	899	26
Australia	325	48	15
New Zealand	79	14	18
South Africa	356	109	31
United Kingdom	2,641	728	28
Non-English speaking . .	53,816	8,348	16

¹ Excluding Canadians.
Source: Reference 1.

Changes in the timing of certification, such as new examination structures which enable both USMGs and FMGs to take the boards earlier in their careers, should improve the FMGs' chances of becoming board certified.

Data (as of 1972) with regard to specialty board certification are presented in Table 39; in all, just over 11 percent of all certifications were held by FMGs. As can readily be seen, certain patterns of specialty choice by FMGs (including Canadians) are borne out; in particular, a relatively high representation of FMGs in physical medicine, pathology, and anaesthesiology is reflected in these figures. The proportion of FMGs (including Canadians) was notably higher in 1972 than in 1967 for several specialties, including colon and rectal surgery, urology, internal medicine, surgery, thoracic surgery, and pediatrics; it was the same in both years in ophthalmology, otolaryngology, and psychiatry, and dropped in dermatology and physical medicine.

The American Board of Medical Specialties recently collected some information from several of its member boards on performance on the written examinations for specialty board certification. Eleven boards reported for

Table 39
NUMBER OF SPECIALTY BOARD CERTIFICATION, BY BOARD AND
COUNTRY OF MEDICAL EDUCATION:
1972

Specialty board	Total board certifications ¹	Graduates of U.S. medical schools	Graduates of foreign medical schools			Foreign graduates as a percent of all board certifications ²
			Canadian	Other	Total	
All boards	135,468	120,195	2,690	12,583	15,273	11.3
Anesthesiology	5,093	4,050	165	878	1,043	20.5
Colon and rectal surgery	388	327	16	45	61	15.7
Dermatology	2,656	2,453	48	155	203	7.6
Family practice	4,520	4,239	55	226	281	6.2
Internal medicine	22,737	21,245	277	1,215	1,492	6.6
Neurological surgery	1,487	1,311	45	131	176	11.8
Nuclear medicine	884	760	20	104	124	14.0
Obstetrics and gynecology	11,331	10,300	221	810	1,031	9.1
Ophthalmology	6,655	6,148	145	362	507	7.6
Orthopedic surgery	6,927	6,364	164	399	563	8.1
Otolaryngology	4,590	4,158	127	305	432	9.4
Pathology	7,396	5,634	197	1,565	1,762	23.8
Pediatrics	13,101	11,101	221	1,779	2,000	15.3
Physical medicine and rehabilitation	803	584	17	202	219	27.3
Plastic surgery	1,032	936	21	75	96	9.3
Preventive medicine	2,186	2,051	51	84	135	6.2
Psychiatry and neurology	10,514	8,919	328	1,267	1,595	15.2
Radiology	9,853	8,671	181	1,001	1,182	12.0
Surgery	17,020	15,312	286	1,422	1,708	10.0
Thoracic surgery	2,580	2,205	43	332	375	14.5
Urology	3,715	3,427	62	226	288	7.8

¹ This does not represent individual physicians, as some physicians may hold more than one certification.

² Including Canadians.

Source: Reference 22.

1972 the number of FMGs and U.S./Canadian graduates taking the written examinations for the first time. Ten boards reported only 1972 examinations; one board reported only a five-year total. For FMGs, a 63 percent failure rate was calculated; the failure rate on individual boards ranged from 18 to 73 percent. One board indicated that of foreign-trained physicians taking its examination after one or more failures, 225 FMGs failed and 84 passed, for a 73 percent failure rate. For USMGs (including Canadians), the failure rate calculated for 1972 for first-time examinations was 27 percent; their failure rate on individual boards ranged from 5 to 30 percent.

Up to this point, comparative FMG and USMG performance has been inferred after the fact from records of performance on examinations. The following

discussion will deal with the attitudes and perceptions of the FMGs and USMGs themselves. These perceptions have been recorded in a series of research projects conducted during the 1960s. They add a valuable dimension to the limited knowledge that we have concerning the capabilities and motivations of the FMG population.

Perceptual Studies of FMG Performance

Two research projects conducted during the mid-1960s have compared the performance of FMGs and USMGs while they were serving as residents. One study involved FMGs and USMGs serving in surgery, internal medicine, and physical medicine and rehabilitation residencies in university-affiliated hospital programs

located primarily in the Northeast. Approximately 50 FMGs and 50 USMGs in each specialty were included in the sample. In one paper on this project, Halberstam and Dasco reported on the performance and ability of U.S. and foreign-trained residents as perceived by both the members of the sample group and U.S. medical educators. The overall proficiency of U.S.-trained residents was considered superior to that of foreign-trained residents by 90 percent of the U.S. residents and 78 percent of the foreign-trained. The medical educators also perceived the USMGs to be better trained and better able to cope with the requirements of residency training than the FMGs (34).

Another paper compared the attitudes and performance of 100 internal medicine residents, split evenly between USMGs and FMGs (35). Those FMGs who were more satisfied with their residency training programs tended to have closer contacts with U.S. peers, fewer contacts with compatriot peers, and less attachment to their home countries. Satisfaction with the program also seemed to be positively correlated with ECFMG examination scores. The FMGs generally conceded the professional superiority of their USMG peers, a perception shared by the teaching program supervisors.

In still another paper, the personality profiles of FMG residents in surgery were compared with the profiles of a number of other medical resident and normative groups, including USMG residents, FMG residents, U.S. college men, and U.S. top and second-level executives (36). The study indicated that FMG residents in surgery showed the same personality profile as U.S. medical residents and second-level executives,

and concluded that the foreign surgeon appears to be more readily accepted as a physician in the United States than is his foreign colleague in internal medicine or physical medicine and rehabilitation.

The other major research effort dealing with perceptions of FMG performance was conducted by Margulies, Bloch, and Cholko (37). Medical educators' perceptions of the comparative performance of U.S. and foreign-trained house officers were measured on 166 pairs of U.S. and foreign-trained house officers and 130 additional FMGs in terms of professional skill, overall competence, and adaptability. Except for questions dealing with personal characteristics, FMGs were rated significantly lower in competence than their USMG peers. FMGs trained in English-speaking countries were judged to be superior performers to the overall foreign-trained population. The researchers concluded that FMGs represent a level of competence significantly lower than the USMGs in the same program of graduate education. They did not conclude that FMGs were professionally incompetent, although it was suggested that serious consideration be given to allowing only FMGs with clearly demonstrated competence to assume patient care responsibilities.

Both these studies revealed that medical competence was considered lower for FMGs than for USMGs. Although a number of questions can be raised with regard to the general applicability of these studies, the major thrust is clearly that FMGs are perceived, however rightly or wrongly, as having less medical competence, *in the American setting*, than their U.S.-trained colleagues.

U.S. CITIZENS IN MEDICAL SCHOOLS ABROAD: A SPECIAL ASPECT OF THE FMG PICTURE

Background

Applications to U.S. medical schools since World War II have consistently exceeded the number accepted by about two to one (Table 40); despite a relatively rapid increase in the number of places, the excess is expected to increase. In 1972-73 alone, almost 22,380 applicants were turned away from U.S. medical schools. In 1970-71, the figure had been nearly 13,500. The rise in

total number of applications has also been notable. In 1967-68, for example, 93,300 applications were received for an average of 5.0 per individual. In 1972-73, about 267,300 applications were received, for an average of 7.4 per individual (22). The percent of total applicants accepted was 38.1, down from a high during the past decade of 58.1 in 1967-68.

Table 40
APPLICATION ACTIVITY TO U.S. MEDICAL SCHOOLS:
1947-48 through 1972-73

Academic year	Number of applicants	Number of applications	Applications per individual	Number of accepted applicants	Ratio of applicants to accepted applicants
1947 - 48 . .	18,820	56,279	3.0	6,512	2.9
1948 - 49 . .	24,242	81,662	3.4	6,973	3.5
1949 - 50 . .	24,434	88,244	3.6	7,150	3.4
1950 - 51 . .	22,279	81,931	3.7	7,254	3.1
1951 - 52 . .	19,920	70,678	3.5	7,663	2.6
1952 - 53 . .	16,763	56,319	3.4	7,778	2.2
1953 - 54 . .	14,678	48,586	3.3	7,756	1.9
1954 - 55 . .	14,538	47,568	3.3	7,878	1.8
1955 - 56 . .	14,937	54,161	3.6	7,969	1.9
1956 - 57 . .	15,917	59,798	3.8	8,263	1.9
1957 - 58 . .	15,791	60,951	3.9	8,302	1.9
1958 - 59 . .	15,170	59,102	3.9	8,366	1.8
1959 - 60 . .	14,952	57,888	3.9	8,512	1.8
1960 - 61 . .	14,397	54,662	3.8	8,550	1.7
1961 - 62 . .	14,381	58,834	3.7	8,682	1.7
1962 - 63 . .	15,847	59,054	3.7	8,959	1.8
1963 - 64 . .	17,668	70,063	4.0	9,063	1.9
1964 - 65 . .	19,168	84,578	4.4	9,043	2.1
1965 - 66 . .	18,703	87,111	4.7	9,012	2.1
1966 - 67 . .	18,250	87,627	4.8	9,123	2.0
1967 - 68 . .	18,724	93,332	5.0	9,702	1.9
1968 - 69 . .	21,117	112,195	5.3	10,092	2.1
1969 - 70 . .	24,465	134,557	5.5	10,514	2.3
1970 - 71 . .	24,987	148,797	6.0	11,500	2.2
1971 - 72 . .	29,172	210,943	7.2	12,335	2.4
1972 - 73 . .	36,135	267,306	7.4	13,757	2.6

Source: Reference 22.

Many U.S. citizens have chosen to seek medical education abroad. In 1971-72, the Institute of International Education estimated that more than 3,710 U.S. citizens were studying medical sciences abroad (22,p. 912). At the end of the 1960s, Americans were thought to be enrolling in foreign medical schools at the rate of about 500 per year (38). It has also been estimated that fewer than one-half of those Americans entering foreign schools actually finish the full course and return to the United States with acceptable credentials (39). The licensing statistics in the United States point to a steady inflow of American graduates of foreign schools ranging between 180 to over 400 (Table 33), and these figures include only those successful in the licensing examinations. In the 16 years for which data are available, over

4,500 initial licenses have been awarded to U.S.-born FMGs, out of a total of 34,595 awarded to all FMGs in the same period.

The figures on students abroad are believed to be underestimates. For example, a recent survey of U.S. medical students at the Autonomous University of Guadalajara indicated that for 1972-73, some 800 had been enrolled in the first year alone (40). In 1971-72, over 600 had been enrolled in the first year class. A survey by the Pan American Health Organization covering the 1971-72 academic year of all foreign students in medical schools in the Americas indicated a total of 1,744 U.S. citizens at Guadalajara alone, out of a total of 1,943 U.S. citizens in Latin America as a whole (and an additional 102 in Canada) (41).

Studies of foreign medical schools by Mason have thrown additional light on the total number of U.S. students in some institutions. In 1969, he found a total of 821 Americans at schools in Italy, the bulk of them at the University of Bologna. He also reviewed schools in Spain, Switzerland, Belgium, and Mexico. In all, he found a total of 2,343 American students in the 16 schools surveyed (38).

A more recent analysis of ECFMG applications from U.S. citizens found a similar predominance of students in Italy (42). Of the 1,165 U.S. candidates taking the ECFMG between September 1968 and February 1970 (including 123 Puerto Ricans), 426 were from medical schools in Italy, another 199 in Spain, 140 in Mexico, and 109 each in West Germany and Belgium. Other countries, particularly in Europe, had smaller numbers of U.S. citizens.

Altogether, 5,972 U.S.-born physicians from foreign schools were identified in the United States in 1970 (1). The bulk of these graduated from schools in Italy, Switzerland, the United Kingdom, Spain, and Mexico. It should be emphasized here that foreign schools refers to medical schools outside both the United States and Canada.

One early study of Americans in medical schools abroad was Greeley's analysis of ECFMG candidates for 1964 (43). Greeley estimated that of the 500-550 Americans abroad at that time, about 300 received degrees and took the ECFMG examination. He reviewed the records of 303 persons who had taken their premedical education in the United States and then had gone abroad for their medical education. The great majority (72 percent) had applied to American medical schools but their performance on the standard Medical College Admissions Test was significantly lower than that of students who were accepted to American medical schools. Of the whole sample, 40 percent had attended schools in Italy, 15 percent in Switzerland, 10 percent in Germany, and 9 percent in Mexico; the remainder were scattered among a variety of countries. Most of the students thus took their medical education in a foreign language. While 57 percent passed the ECFMG examination the first time, Greeley expected at least 70 percent would pass eventually.

The experience of Americans after graduation from foreign medical schools has barely been explored. Mason's profile of 314 successful applicants to State licensing boards is one effort (39). On average, these U.S.-born FMGs spent longer in medical school than if they had attended American schools (5.4 years, and longer for those who had to learn a foreign language).

Most were satisfied with the quality of education they received abroad. Some said that clinical training was insufficient, but that this could be compensated by an American internship. Many complaints voiced by individual foreign-trained Americans related to a feeling of discrimination on returning to the United States, in terms of jobs available, licensing, and incorporation into the American medical profession.

COTRANS

The mechanisms for transferring into the U.S. health care system at any point (e.g., in the middle of undergraduate medical education or at the end of training) are not easy. In 1970, the Association of American Medical Colleges established a "coordinated transfer application system" or COTRANS, to assist in evaluation of credentials of U.S. citizens seeking transfer from foreign to U.S. medical schools, basically through participation in Part I of the National Board of Medical Examiners. COTRANS is not a matching or placement service. Transfer applicants must apply to medical schools directly, and acceptance decisions are made by the admissions committee of each school. Under the initial program, no new positions were to be created. Such vacancies as exist in second, third, or fourth year classes of U.S. medical schools are open first to transfers from U.S. two-year schools or other four-year degree programs. Only vacancies existing after those transferees have been accommodated can be filled by COTRANS applicants.

Many schools have been reluctant to admit U.S.-born foreign transfer students because of the difficulty of evaluating their previous performance (44, 45). Between 1960 and 1969, for example, a total of 377 students transferred from foreign into U.S. schools, the majority into the third year (46, pp. 1219-20). In all, 564 COTRANS applicants have been accepted during the first four years of its existence (1970-1973). Preliminary data for 1973 suggest that 1,046 COTRANS applications were approved as eligible for Part I of the National Board. Of the 1,046, a total of 957 participated in Part I of the National Board and 292 passed. Data from the AAMC Fall Enrollment Questionnaires show that 36 of 49 participating medical schools in the U.S. admitted 153 COTRANS students in 1973, compared with 214 the year before (47). Compared with the total number of U.S. citizens in foreign schools, however, these transfers represent only a fraction of the potential number of Americans who might want to be qualified to return to the United States for the remainder of their medical education.

The "Fifth Pathway"

Entering the American system after completion of didactic work abroad is currently a cause of concern and complaint from U.S. foreign medical graduates (48, 49). Before granting eligibility for its certification, the ECFMG generally required that the candidate have completed the curriculum requirements in the country of medical education and also have reached the point in his education where he would be eligible for licensure in that country if he were a citizen. Some countries require students to take an internship there before issuing a license. This internship may correspond to more nearly to the clinical clerkships offered in most U.S. medical schools and, thus, is not an internship in the American sense. Furthermore, U.S. hospitals heretofore have not usually appointed physicians directly into a residency. These factors have often meant that U.S.-born foreign medical graduates, like their foreign-born counterparts, may have to take an additional year of internship or similar training to fulfill all requirements for the Doctor of Medicine degree.

Mexico is a case in point. Graduates of Mexican schools must serve six months to one year of social service as the last part of medical school before being eligible for the medical doctorate degree; only then are they considered truly medical graduates. One year of internship (i.e., clinical clerkship) is also required prior to licensure. Having been forestalled in attempts to circumvent this requirement before being able to take an American internship, six American medical students from the Autonomous University of Guadalajara filed suit charging the AMA, the American Hospital Association (AHA), the ECFMG, and the Joint Commission on the Accreditation of Hospitals (JCAH) with violation of the Sherman and Clayton Anti-Trust Acts (18, p. 23) and alleging interference with their civil rights. They maintained that the ECFMG's policy of requiring foreign-trained physicians to have achieved eligibility for licensure before being admitted to its examination discriminated against U.S. students in Mexico, by forcing them to spend extra time before being able to take a U.S. internship. This in turn, it was alleged, was compounded by policies that effectively penalized hospitals which accept U.S. graduates of foreign medical schools who do not hold ECFMG certification, through

loss of accreditation of both the graduate medical education program and the hospital itself. In the intervening period, the suit changed somewhat. Five of six plaintiffs withdrew, and the case against the AMA, the AHA, and the JCAH was dropped. The thrust of the case against the remaining defendant was also modified, and the chief objection appeared to be against the ECFMG requirements that FMGs must meet the requirements for licensure in the country in which they are educated. In October 1973, the remaining action was dismissed in a lengthy legal argument.

The AMA has liberalized the requirements for entrance into graduate medical education for FMGs. As of July 1971, foreign medical graduates are being allowed to substitute a year of supervised clinical training under the direction of a medical school approved by the Liaison Committee on Medical Education for the internship or social service required by a foreign school. This is referred to as the "Fifth Pathway" (50). To gain such a position, the student must have completed premedical undergraduate work in an accredited U.S. college or university of a quality high enough for matriculation in a U.S. medical school. He must also have successfully completed all other formal requirements of the foreign school. Finally, he must pass a screening examination acceptable to the Liaison Committee (such as the ECFMG examination). (He need not obtain ECFMG certification, however.) The National Board of Medical Examiners devised a special examination — the American Medical Screening Examination — as such a test. After successful passage through this supervised academic year, the student is eligible to enter an AMA-approved graduate training program. Twelve U.S. and two Canadian medical schools were participating in this program as of 1972. It should be noted that only 14 States presently permit Fifth Pathway participants to qualify for regular medical licensure, without having fulfilled all the requirements for an ECFMG certificate. The new AMA policy could be seen as a means of giving differential treatment to U.S. citizens graduating from foreign medical schools vis-a-vis foreign nationals graduating from those same schools, and the international implications of this will need to be considered, if the program expands to any great extent.

FUTURE DATA COLLECTION AND ANALYSIS

The limitations in the present data base on FMGs have been emphasized throughout this chapter. To reiterate, the problems of analyzing the FMG component of U.S. physician manpower are centered in several areas: the true magnitude of the net flow of foreign-trained physicians into the U.S. over time; the magnitude and characteristics of that part of the FMG population working in medical or allied fields but not known to the professional or regulatory agencies; the location, professional activities, and professional achievements of the "known" FMG component; and, finally, the quality of the health care services delivered by FMGs.

An improved and extended system for gathering, storing, processing, and analyzing information on FMGs—and similar information on USMGs—is a pressing need. Planning for the use of health resources in the United States and for the use of health manpower in particular—will be less than optimally rational as long as these data are unavailable. Much of the data may not become available any time soon, but the more fruitful areas of inquiry might at least be outlined.

One primary difficulty has been that no single identifying number is in use which would allow an FMG to be followed throughout his stay in the United States, regardless of changes in visa status, activity, location, marital status, and so forth. One solution to this problem may be in the Social Security Amendment of 1972 (P.L. 92-603), which contains a requirement (Section 137) that social security numbers be assigned to (among others) all aliens at the time of their admittance to the U.S. as permanent residents or for employment, and to all other aliens at such time as their status changes to one of the above categories. Implementation of this requirement should facilitate the establishment and maintenance of a single primary source of contact which will be as inclusive as possible.

Aside from the need for an identifying number, the need for research into specific aspects of the FMG issue can be assessed from several vantage points. The items noted below do not by any means exhaust the possible areas for productive research; they are intended to give a topical overview of the situation.

Topics for Data Collection and Research

Demographic and Other Characteristics of FMGs

To promote a more rational process of health manpower planning at both the national and local levels, a more complete and primary source of data on all physicians must be established and maintained. In the case of FMGs, this data base must be expanded beyond the usual items such as age and sex, location, current professional activity, and specialty. An ideal data base on FMGs would also include country of birth; country of last permanent residence; last citizenship; age at entry; visa status upon entry into the U.S.; subsequent changes; and current visa status. In terms of medical education and training, such items as medical school, graduate training abroad, graduate training in the U.S. (in terms of specialty, level, and duration), ECFMG performance, and competency in English are all significant parameters. Similarly, details of past and present professional activity are important topics, e.g., licensure history, specialty board certification, affiliation (or nonaffiliation) of hospital, and type of practice. Details about specific location within urban areas are also crucial.

One area of particular significance is the economic aspect of the dual USMG/FMG manpower pool. Information on income for U.S.-trained versus foreign-trained physicians by specialty, activity, location, and other parameters is needed. The relative costs of medical education, graduate training, or retraining represents another important topic for research, especially in comparison with similar costs for nonphysician support personnel.

Quality of Care

An issue of overriding concern to professionals and laymen alike has been the quality of health care services delivered by foreign medical graduates, in comparison both with peer-oriented standards and with expectations of consumers. The question has been raised—but not answered—about differences in performance and quality of care delivered. Quality is a subjective concept that is not easily measured, but it can be translated into more precise terminology. The concepts of benefit, effectiveness, or efficiency, for example, are all more workable terms which convey a similar meaning. They are, furthermore, open to quantification—they can be restated in such a way as to allow for a wide range of evaluative actions.

The definition of quality in these (or other) terms can be made from several individual viewpoints — the professional or the consumer, for example — or from a more composite viewpoint — society, for example. Quality can reflect purely technical and unitary measurements, e.g., number of specific services performed per time or manpower unit, or more subjective considerations, e.g., patient satisfaction in terms of time or money expended. In short, quality is a complex concept; it is particularly complicated when applied to foreign physicians, especially in comparing them with U.S.-trained physicians.

With regard to FMGs, two parameters of quality might be isolated for primary attention. The first is the need for measures of professional competence in the direct delivery of care in the American setting, measures sufficiently precise and discriminating that they can be applied equally well to USMGs and FMGs. Second, there is a need for common measures of professional knowledge and achievement — in short, standard examinations and requirements for entry into graduate medical education, licensure, and specialty board certification. FLEX and the screening examination which may be developed by the National Board of Medical Examiners are initial steps in this area. Ways of administering these examinations and collecting data on the group that fails, as well as on the group that passes, will also be fruitful topics of research.

Immigration and Emigration Aside from the migration information (country of birth, country of last permanent residence, etc.) noted in the section above on demographic characteristics, other information would be useful in clarifying processes and patterns of physician migration. Above all, some measure over time of the number, destination, and various other characteristics of those FMGs who leave the United States is needed.

Motivations for immigration and/or emigration, particularly within the context of the worldwide movement of health professionals, in one aspect of the situation which needs more careful analysis. The expectations of FMGs prior to arrival, their information (or lack of it) about programs and career possibilities, their satisfaction (or lack of it) with training and activities here and in their home countries, and their potential employment opportunities in their home countries are all areas deserving further clarification. These factors can be assessed from the point of view of FMGs who remain in the United States *versus* those who leave the country (and may or may not have returned home).

Further exploration of the "pull" factors is needed; for example, are economic or professional considerations paramount? Information on migratory patterns is particularly crucial in beginning to identify which groups of FMGs might be expected to remain in the U.S. and become permanent additions to the physician manpower pool.

Finally, the place of the United States in the worldwide movement of physicians must be studied more closely. The implications of physician migration for the donor countries is one aspect of the constellation of potential topics for research which should not go unattended. One major study by UNITAR which has focused on students and professionals gives many insights into the migration process in general, but it did not include physicians. The proposed study of international migration of physicians and nurses, expected to be undertaken by WHO, should provide additional data and perceptions to describe the patterns of migratory flow among nations and to elucidate the underlying reasons for migration.

Analyses

Research and information exchange do not take place in a vacuum. The purposes to which such efforts are directed should be unambiguously stated; in so doing, the justification for such efforts may highlight the more crucial areas of attention.

The first step in data collection is to identify the population(s) to be included. Although the entire group of FMGs entering, working, and living in the United States is the proper focus of long-term data collection and storage, certain subgroups of FMGs can be isolated for special analysis. These subpopulations comprise the following:

1. FMGs currently known to professional, regulatory, or immigration agencies
 - (a) those in unapproved training programs,
 - (b) those in activities other than office or hospital practice or graduate medical education;
2. FMGs not yet accounted for or known to those agencies — the so-called "unknown" FMG population;
3. FMGs who enter the United States as non-immigrants;
4. FMGs who enter the United States directly as permanent residents;
5. FMGs who enter the United States as nonimmigrants but convert to immigrant status;
6. FMGs who leave the United States; and
7. U.S.-born FMGs.

Following are some illustrative issues which could be explored given the types of data outlined above.

In the area of immigration (worldwide or U.S.-oriented), collected data would allow subgroups of FMGs to be compared on a broad set of variables to ascertain what factor or constellation of factors have been most instrumental in motivating FMGs to migrate, to settle in a new land, or to return home, and thus to predict the future behavior of similar groups. This might be particularly pertinent in assessing the possible behavior of exchange visitor FMGs in terms of converting to immigrant status.

Samples of FMGs with recognized credentials of one sort or another (e.g., full State license to practice, passing score on ECFMG examination, or appointment to an approved training program) might be compared with samples of FMGs lacking such credentials, in order to clarify what factors might be operative in creating the so-called FMG "underground". This might, in turn, lead to potential remedial steps to help the FMG underground move to a higher professional level.

With regard to professional achievement, samples of FMGs and USMGs might be compared to ascertain what variables are most strongly associated with differences in licensure, specialty board certification, position in affiliated or nonaffiliated hospitals, or whatever. Related questions involving the issues encompassed in "quality of care" might also be addressed. For example, whether FMGs in a given setting are as effective as USMGs in the delivery of health care might be measured. If the FMGs were found to be less effective, variable(s) which account for this divergence from the USMGs could be isolated.

More needs to be known about U.S.-born FMGs, especially if this group becomes a more noticeable constituent of U.S. physician manpower. Specifically, the demographic, educational, and socio-cultural backgrounds of U.S. citizens educated abroad are of primary interest. Their educational experiences abroad, their entry into graduate medical education in the U.S., and their assimilation into professional life here are other areas open to future research.

The issue of whether the United States has a real or only an apparent shortage of physicians may not be resolved satisfactorily for some time, involving as it does such questions as geographic maldistribution of both USMGs and FMGs. One useful analysis, given the data suggested above, would be on the subject of location of practice of FMGs *within* urban areas in order to clarify whether, in this one instance, FMGs are helping to relieve the lack of health care services to certain inner city or ethnic areas. Similarly, analysis of the location of practice by type of institution and patient treated, especially by the "unknown" FMG component, might help to clarify whether FMGs are filling positions heretofore unrecognized as physician-dependent.

These few examples of possible analyses are given to illustrate the types of questions which might be asked, given a suitable data base. In the absence of that data base, the answers to such questions remain speculative. Informed attempts to improve the U.S. medical training of the FMG, to enhance the quality of care delivered by FMGs, to quantify and characterize more precisely the migratory patterns of FMGs, or to describe more completely the composition of the FMG component of U.S. physician manpower will consequently also remain unrealized.

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CHAPTER



ACTION ALTERNATIVES IN RELATION TO
QUALITY, ACCESSIBILITY, AND
COST OF HEALTH CARE

Available data, such as those just reviewed, do not throw much light on the issues of the impact of the utilization of FMGs on the quality, accessibility, and cost of health care in the U.S. At present, there are no direct measures of the quality, cost, or nature of the health care services provided by FMGs in the United States, or of the types of patients to whom they are providing service. Until studies such as those suggested in the previous section are undertaken, one can only infer from available data and expert opinion what the impact of FMGs might be and suggest possible policy options and action alternatives based on these inferences. This inferential approach is hampered by the fact that most available data and opinions about FMGs do not take account of the wide variation in the backgrounds of foreign physicians or look at trends over time. Nevertheless, a number of action alternatives

related to national policies will be identified and assessed in this chapter to stimulate thinking about and research on FMGs in the United States.

These action alternatives are not recommendations; they are ideas to be discussed. Their ultimate feasibility and implementation are issues to be decided by others. They are presented as though they were discrete actions, but this does not imply that they are mutually exclusive. Two or more action alternatives taken together might have synergistic or multiple effects, necessitating a careful assessment of the ramifications of both single and combined actions. Obviously, the ultimate outcome is envisioned as a coordinated set of policy options along a broad front, each action alternative focusing on some aspect of the FMG situation, but all working together toward the same national goals.

BACKGROUND

The migration of foreign-trained physicians to the United States and the place of the FMG once here has received official attention of varying degree from time to time, most explicitly in 1967 as part of the work of the National Advisory Commission on Health Manpower. President Lyndon Johnson established the Commission to "develop appropriate recommendations for action by government or by private institutions, organizations, or individuals for improving the availability and utilization of health manpower" (1, p. 1), and a Panel on Foreign Medical Graduates was named.

One overriding recommendation was made in the Report of the Commission which impacted significantly on FMGs (1, p. 18):

The United States should produce a sufficient number of physicians to meet its needs and, further, . . . should assist other countries, particularly developing nations, to improve their systems of medical education and their levels of medical practice and public health.

Three other recommendations were also stated which were directed specifically at FMGs (1, pp. 43-44):

. . . at a minimum, foreign-trained physicians who will have responsibility for patient care should pass tests equivalent to those for graduates of U.S. medical schools. The National Board of Medical Examiners provides an objective testing service which should be utilized just as it is for graduates of U.S. schools. Issuance of an immigrant visa on the basis of Third Preference should be contingent upon satisfactory performance in the examination.

. . . before foreign medical graduates are permitted to enter training programs with responsibility for the care of patients, they should be required to participate in an orientation and educational program during which their competence in the basic and clinical medical sciences, in English, and other appropriate fields would be assessed, and remedial instruction provided where necessary. . . . Such orientation programs should be conducted by a consortium of medical schools, hospitals, and educational institutions on a regional basis. . . .

... a Commission on Foreign Medical Graduates be established outside of government. Financed by appropriately interested foundations and health associations, with contributions from the Federal Government if necessary, such a Commission could gather and analyze data on FMGs which are presently unavailable from any source. It could then provide advice to all institutions, in and out of government, which are involved with FMGs, and coordinate the various actions which may be taken to implement an overall national policy.

Although these recommendations have been widely disseminated since the appearance of the Commission

Report, they have not been implemented. In 1970, the Commission on Foreign Medical Graduates (CFMG) was established under the sponsorship of eight national professional associations, but the report of the CFMG on its studies of FMG problems has not been completed. The CFMG will merge with the ECFMG by summer of 1974, although its functions will continue. Some of the recommendations made by the Commission and the Panel (2) seem as appropriate today as they were in 1967, and they are included in the discussion of action alternatives in this chapter.

THE CURRENT SITUATION

The data reviewed in Chapter II do make clear that increasing numbers of FMGs are entering the U.S. each year and becoming permanent residents. FMGs are proportionately more often found in graduate medical education positions (especially in nonaffiliated hospitals) and in full time hospital care than USMGs. They are most likely to be found in metropolitan areas, especially on the East Coast. FMGs tend to be younger and more often female than USMGs. They are less successful in obtaining unrestricted, permanent licenses to practice than USMGs. An unknown, but substantial, number of FMGs are practicing with temporary or institutional licensure only. FMGs educated in English-speaking countries are usually more successful in passing U.S. medical licensure and credentialing examinations

than those educated elsewhere. Since more FMGs are coming from Asia, they may be less conversant with our language and health care practices than earlier FMGs, although no direct evidence for this exists. The few studies that have been undertaken in the area of quality of care suggest that FMGs are *perceived* by U.S. medical educators and themselves as less proficient than USMGs.

These data have led some U.S. physicians and health officials to conclude that FMGs taken as a whole dilute the quality of health care provided to Americans, decrease the number of educational and professional opportunities for American students and doctors, and do not alleviate the problem of geographic maldistribution of health care services in the United States.

QUALITY OF MEDICAL CARE

If FMGs are assumed to provide a quality of medical care not equivalent to that provided by graduates of U.S. medical schools, then relevant policy options include reducing the number of FMGs providing medical care to Americans and/or upgrading the skills of those who provide such care. One means of reducing the total number of FMGs in the United States is to reduce the numbers coming to this country. An action alternative often advocated in this context is modification of existing immigration laws and policy.

Immigration Policies and Laws

As discussed in Chapter II, virtually all foreign-born FMGs enter the United States either as exchange visitors

(J-visa) or as immigrants, and in very recent years, the immigrant group has comprised, to a large degree, exchange visitors who have changed status. These facts suggest that action alternatives to reduce physician immigration must focus on those who come as exchange visitors. One action alternative which has been suggested is *"to terminate the present international educational exchange program and replace it with a more systematic and nationally coordinated international exchange program involving formal agreements between the United States and the governments of other countries."* This might be organized on a bilateral agreement basis, through multilateral agreements involving the World Health Organization or a combination of both. Under such arrangements, the United States could agree to

provide specified types of graduate medical training for individuals selected by the government of a developing country (or a consortium of medical schools in that country) to fill faculty or key clinical posts in that country. Candidates selected for such training opportunities would be assured positions on the completion of the training experience and would be committed to return to their home country" (3, p. 49). This action would require mutual agreements on international policy and extensive international cooperation which would no doubt demand lengthy and involved negotiations. Existing legislation might have to be amended and State Department participation would be required.

The historical changes in exchange visitor regulations, especially regarding the requirement to leave the U.S. for a two year period, were reviewed in Chapter II. There is some sentiment in other countries for a more stringent application of that provision. For example, in 1971, a Report of the Inter-Ministerial Group on the Brain Drain prepared for the Government of India recommended that *all exchange visitors in the U.S. be required to return to their home countries after completion of their training and to reside in the home country for four years before becoming eligible to immigrate to the U.S.* (4, p. 59). This requirement would prohibit the FMG from residing and working in a third country (e.g., Canada) for a period of time and then returning to the United States.

Enforcement of a requirement for exchange visitor trainees to return to the home country and extension of the time requirement from two to four years might decrease the number of FMGs who eventually settle in the United States in two ways. First, it might reduce the number of physicians applying for training via the exchange visitor route. Second, it might reduce, but not necessarily eliminate, the eventual return to the United States of those who still elect to come here for training. To return to the home country for four years might be perceived by the FMG as something other than a temporary, short-term arrangement. It might also provide an opportunity for professional and personal roots to be established and thus make emigration to this country less attractive.

Two recent studies (5, 6) show that when the requirement to leave the U.S. for a two year period was in effect, over two-third of the FMG interns and residents who were in the United States in 1963/64 were also here in 1971/72. These studies suggest that a "return home" requirement would have to be strictly administered and enforced to insure that trainees leave the U.S. after their training. This implies that improved and additional Federal mechanisms are needed for

monitoring the emigration of FMG trainees from the United States. If the requirement that social security numbers be assigned to aliens were extended to exchange visitors as well, this would facilitate the monitoring process.

If a four year "return home" requirement were vigorously pursued, it might shunt more physicians into the immigration pathway. To implement reduction of influx of FMGs, both the exchange visitor route and the immigration route would have to be considered because the two are closely intertwined. A coordinated approach involving both routes would be most effective. If physicians were removed from the nationwide shortage schedule (Schedule A), approximately three-quarters of the immigrant FMGs would be affected, since labor certification is required for non-preference immigrants, two occupational preference categories, and all Western Hemisphere immigrants. *Basic professional standards should be revised for all immigrants admitted in classifications requiring labor certification, as well as all nonimmigrants admitted under "H" visas, in order that physicians admitted to this country to practice medicine, are in fact, eligible for full, unrestricted licensure.*

If it were determined that physicians were scarce only in specific geographic areas, an FMG would not automatically be given labor certification upon meeting the other qualifications. He would have to demonstrate that he was planning to reside in a scarcity area, and the Department of Labor would have to assure that no unemployed U.S. physician was willing to relocate and accept employment there. Physicians could be removed from Schedule A, but a professionally sound formula or standard would have to be devised which would allow designation of geographical locations as physician shortage areas. The Department of Labor is subject to court action if an alien successfully challenges such a formula or its application in determining shortage areas. Development of such a formula is not an easy chore, as those responsible for developing similar procedures to identify physician shortage areas in which to place National Health Service Corps physicians and to evaluate educational loan-forgiveness programs have discovered. *Methods for development of a professionally sound formula which would allow designation of specific geographical locations as physician shortage areas could be explored.*

Graduate Medical Education

Some reasons for FMGs settling in the United States are related to "push" factors, and are outside the purview of the U.S. Government. Others are more

amenable to modification within the United States because they are related to "pull" factors. Action alternatives which would limit immigration of FMGs to the United States by reducing the incentives for foreign physicians to practice here can be considered.

As noted earlier, internship and residency training opportunities appear to be a key factor in FMG immigration because, regardless of eventual career plans, postgraduate training is the avenue by which most FMGs enter the United States. Aside from the obvious opportunity for specialized training not available throughout the world, the economic incentive for interns and residents is strong. Recent AMA data indicate, for example, that the mean annual salary in 1972 in hospitals not affiliated with universities was about \$10,140 for interns and \$11,210 for residents (7, p. 932); salaries in affiliated hospitals are somewhat lower. The trend in salaries continues upward, however. Consequently, the salaries available to foreign-trained physicians serving as house officers often exceeds what they could make at home, either in training or, in some cases, in practice.

The output of graduates from U.S. medical and osteopathic schools is expanding. If the numbers of training programs are not increased simultaneously, USMGs would intensify competition for training positions and reduce the opportunities available to FMGs. Federal support to domestic medical schools could play an important role in determining whether greater numbers of U.S. graduates compete for graduate training positions filled by FMGs at present.

Raising the quality of graduate medical training abroad could indirectly impact on quality of care in the U.S. and numbers of FMGs coming to this country. Lack of adequate opportunities for postgraduate training in donor countries has been identified as an important cause of physician migration (8, 9) and an international conference sponsored by the Josiah Macy, Jr., Foundation in 1970 concluded that developed countries should assist in strengthening such training programs (10). The development of "centers of excellence" was seen as a means of diminishing the outflow of physicians from developing countries. In general, they are proposed for postgraduate work, and are not simply an expansion or upgrading of undergraduate medical school programs. *Centers of excellence are seen as a mechanism to improve the health status of the developing countries and as a possible means of retaining foreign physicians in their own countries (or in their own regions) or of encouraging the return of those physicians who have already immigrated to the United States or other developed countries for advanced training or employment.*

Before supporting the development of new program centers, studies need to be undertaken of the impact that existing centers (such as the Jinnah Postgraduate Medical Center, the All-India Institute, and the Programas de Centros Multinacionales) have had upon health care in their nations (11, 12). Important questions regarding their relevance to the primary health problems of their people, their goals, their financing, and their administration need to be explored.

Educational and Professional Requirements

Another set of action alternatives which relate to the national goal of providing quality medical care for all Americans involves increasing the educational and professional requirements of FMGs. Depending upon the entry point into the health care system, these requirements currently can include ECFMG certification, internship, FLEX or other State licensure examinations, and perhaps specialty board certification. The most critical requirements center on those involving examinations.

Along those lines, a valid measure of the competence of all physicians to deliver quality care is sorely needed. Accordingly, recent proposals by The Committee on Goals and Priorities of the National Board of Medical Examiners as part of its review of evaluation procedures in medical education would *establish an entirely new system of examination, applicable to medical graduates of domestic and foreign schools alike* (13). A "Qualifying A" examination is to be devised "to evaluate performance characteristics requisite for providing patient care in a supervised setting." Successful performance on Qualifying A (among other things) would qualify a candidate for a "permit to practice in a supervised setting," and this permit would be required of all graduates (from both U.S. and foreign medical schools) for entrance into residency training. Furthermore, the Committee has agreed that an evaluation procedure is needed which will better assess English language capability and potential adjustment to the U.S. medical education and health care delivery system. To this end, it was recommended that a new evaluation instrument be designed, and successful performance on it would be a prerequisite for the Qualifying A examination for foreign-born FMGs. Should these recommendations eventually be implemented, this two-stage qualifying procedure for entrance into residency training for FMGs would not only provide a more comprehensive screening device, it might also have some depressive effect on physician migration to the United States.

Actions such as those proposed by the National Board for a new examination structure take time to plan, test, and implement. As an interim step, therefore, modification of existing examinations has been suggested as a feasible approach. Since the ECFMG certification process is the principal screening mechanism for ensuring that FMGs enter the U.S. health care system at roughly the same level as USMGs, one action alternative could be to make this examination more stringent, for example by raising the passing score to a higher level, using the examination as it is currently structured. Another possible interim measure might be the substitution of National Boards Parts I and II for the ECFMG examination. Existing regulations for eligibility as a non-candidate (for certification as a Diplomate) require modification by the National Board of Medical Examiners in order for FMGs to sit for the examination. At present the examinations are given only in the United States and Canada and, under special circumstances, in selected foreign locations. It should be emphasized that the Federal government has little leverage in these matters, which are essentially the concern of professional and educational institutions. Furthermore, it could be expected that such steps might be protested by, for instance, U.S.-born FMGs.

Other considerations of an economic nature must be noted in connection with these action alternatives. Raising the required professional standards for participation in Federally or State-financed health care delivery programs implies that salaries must be made commensurate with the higher standards. This in turn suggests that a basic question of cost be addressed: shall the same numbers of physicians (who meet the higher standards) be utilized, regardless of the higher costs implied, or should task analysis studies be done to determine if the utilization of physician extenders, other professionals, or mid-level personnel would provide quality care with less additional cost?

Furthermore, establishing nationwide standards as to the quality of medical services and/or Statewide guidelines as to the requirements for health professionals in State institutions will not immediately eliminate the presence of FMGs who are not fully qualified. Consequently, implementation of these types of action alternatives implies that greater care will need to be taken to ensure that unqualified or marginally qualified FMGs are not driven deeper into unrecognized or borderline positions.

Another action alternative that might curtail the number of FMGs coming to the United States would be *modification of the ECFMG regulations limiting candidates to only one repeat examination*. These steps might

be expected to decrease the influx of FMGs to this country over the short run, but foreign schools conceivably could modify or expand their curricula to provide their students with the material needed to achieve the passing grade on the ECFMG. Thus, in the long run, actions of this sort might result in a population of FMGs better assimilated into the U.S. medical care system, but not necessarily an appreciable decrease in the number entering the system. If this modification were made, there surely would be protest from U.S.-born FMGs who were not allowed to repeat the examination.

Most of the action alternatives suggested above for changing the requirements for entry into the U.S. medical care system (particularly into graduate medical education) are likely to invite resistance and charges of unfairness from the FMG population seeking entry into an approved internship and residency program or full State licensure. For example, any effort to make the ECFMG examination more difficult would bring objections from foreign physicians already here who have failed at least one time or who have not yet taken it; similar objections also might be anticipated from foreign physicians—or, more important, U.S. students still abroad who expect to take it in the near future.

Another important caveat to the overall effectiveness of the action alternatives discussed above should be noted. None of the presently existing examinations adequately measures the competence of the FMG to communicate with an American patient. This ability to communicate effectively with a patient is considered one of the more important determinants of the quality of care for any physician. If this communication skill cannot be tested appropriately, there is no assurance that the quality of care delivered by a foreign medical graduate would be predicted accurately by successful performance on any examination. This is one area in which the National Board proposals would appear to be a significant step forward.

Government financed health programs are one area in which raising professional requirements has been suggested as a feasible alternative. *With a reasonable time period (e.g., five years), all physicians serving in public institutions or the National Health Service Corps or in other ways receiving payment under Medicaid or Medicare could be required to be fully licensed in order for the program to qualify for continued Federal funding.* Some exception to this requirement might be provided for bona fide interns and residents in approved training programs for a stipulated length of time (e.g., the length of the full residency program up to the Chief Residency year). Recognition of internship or residency

status could be contingent, furthermore, upon successful fulfillment of some specified criterion, such as passage of the Qualifying A examination proposed by the National Board of Medical Examiners. In any case, it should be stressed that the impact of such an action would have to be weighed carefully. The number of physicians in these programs who currently do not meet such requirements are not known at present, and early implementation of such an alternative is probably not possible.

More relevant to FMGs are professional requirements in State-financed institutions. In order to staff public institutions, most States issue temporary or limited licenses valid only under certain conditions or for a particular institution. Data on the exact numbers of FMGs who are not fully licensed and working in State mental hospitals are not available, but there are indications that the number is quite high. For example, data from a recent survey of State mental hospitals conducted by the American Psychiatric Association indicated that 60 percent of the filled psychiatric positions in the hospitals responding were held by FMGs (14). One-fifth of the hospitals had over 80 percent FMGs, and at least five hospitals were staffed completely by FMGs. Clearly, State mental hospitals and other public institutions such as chronic care hospitals, county hospitals, and tuberculosis sanitariums represent areas where an acute physician manpower shortage would exist without continued utilization of FMGs.

A recent judicial decision in Alabama established minimum constitutional standards for adequate treatment of the mentally ill and retarded who are involuntarily confined (15). This case may bring the question of quality of care provided by temporarily licensed FMGs to national prominence. The decree specifically stated that mental health personnel in State institutions must meet the licensing and certification requirements promulgated by the State of Alabama for those engaged in private practice elsewhere in Alabama. It also prescribed the minimum number of treatment personnel (by professional category) for each unit of 250 patients which would satisfy staffing requirements. If the decision is upheld (it is currently on appeal in the U.S. Court of Appeals in New Orleans as case No. 72-2634), and if similar decrees are issued elsewhere, FMGs holding temporary or limited institutional licenses could not longer be qualified to practice. Thus, the "Alabama decision" could have the effect of curtailing the number of training or employment opportunities, especially for FMGs.

With regard to nationwide standards of quality of care (as opposed to treatment in State mental institutions), P.L. 86-778 provides that the Secretary of Health, Education, and Welfare develop "guides of . . . recommended standards as to the level, content, and quality of medical care and medical services" (16) in order to help State agencies expand the coverage and improve the quality of medical care, particularly on behalf of needy and low-income individuals. The Federal Government could move ahead more directly in carrying out this legislated mandate. Other Federal legislation (P.L. 92-603) provides for expanded peer review in the form of professional standards review organizations (PSROs), as a means of evaluating the quality of care provided by the entire health care delivery system (17). Promulgation of these types of quality of care guidelines could well have the effect of decreasing the utilization of foreign physicians or at least that portion of the FMG population which is not fully licensed. It would appear that further Federal consideration of these areas is needed, in order to ensure that steps taken to implement these alternatives would be consistent with overall national policies regarding FMGs.

Additional Training

Provision of training for those FMGs who are not fully qualified but who are legally entitled to remain in this country is another means of improving the quality of medical care in America. This training would be aimed at those FMGs who have not passed any examination required for licensure or appointment to hospital training programs, but who are providing patient care under limited or temporary licenses or in unrecognized positions.

One action alternative would be to provide immigrant FMGs with one year of clinical clerkship similar to the last two years in U.S. medical schools or the year of supervised medical training given U.S. citizens pursuing the "Fifth Pathway." This training might precede qualifying examinations for foreign-born FMGs.

Many FMGs may require special training to enable them to achieve their maximum potential. A barrier to the optimum effectiveness of some FMGs is their lack of facility with the English language and idiom, even when they may have passed written examinations in English. An action alternative to assist these FMGs would be to *provide intensive programs in language*

training for FMGs who plan to remain in the U.S. Some such courses are currently offered at a number of universities; a variety of courses would be needed, tailored to the proficiency the FMGs already have in basic, idiomatic, and scientific English.

The effectiveness of some FMGs may also be hampered by their lack of experience in, and unfamiliarity with, health care delivery in this country. The recommendations of the National Advisory Commission on Health Manpower and the guidelines of the AMA Council on Medical Education both call for *orientation programs* for such FMGs. The Council's guidelines recommend that those hospitals which appoint FMGs have a program of activities which will assist the new trainees in adjusting to their day-to-day work and the American culture (18, p. 351). Very few programs have developed. One is sponsored jointly by St. John's Hospital in Detroit and St. Louis University. Such programs could be evaluated and, if judged effective, duplicated elsewhere. Language and acculturation programs could be combined in many cases, of course.

Due to the heterogeneity of the FMG population, it is difficult to specify the exact content of such programs. They would include the organization and operation of the U.S. health care delivery system, health care institutions, and medical laws and ethics, as well as the expectations of various U.S. patients regarding the provision of medical care, and other important issues such as individual worth, illness, and death. Individual counseling might well be needed for those FMGs with special problems in adapting to the U.S. scene. Perhaps the work of the American Council for Refugees in New York City could provide a model for such counseling.

Several considerations suggest that such programs would be best provided in a university medical school setting. The resources required for such programs are probably beyond the means of all but a few of the major centers of graduate medical training. The univer-

sity is already equipped to offer a large portion of the proposed curriculum. The economies of scale realized by providing a few programs with large enrollments rather than many programs with relatively smaller enrollments could be considerable. In addition, if one objective is to achieve a standardized and homogeneous level of competence among FMGs entering graduate medical training, this is more likely to be accomplished by a standardized university-based curriculum.

Some hospitals and medical schools are currently conducting review courses for the ECFMG examination. Heretofore, programs of this nature have been privately funded, for the most part, and have served relatively few FMGs. *Another action alternative would be to provide more programs of this type with public funding.* Before implementing this alternative, detailed information would be needed about such factors as the heterogeneity of the FMG groups enrolled, the total costs of various programs, and the results to be expected. Many medical educators are critical of these courses as they now exist. The Division of Manpower Intelligence (DMI) of the Bureau of Health Resources Development (BHRD) is at present supporting an evaluation of existing review programs to assess more definitely their effectiveness.

One possible source of resistance to any action alternative to upgrade FMGs' skills cannot be overlooked. Aid to programs which improve graduate educational and employment opportunities for foreign nationals, while U.S. citizens are denied the opportunity of a medical education, engender a notable lack of political support. Clearly, the review courses would have to be offered to U.S. nationals who attended foreign medical schools. Beyond that, a gradual reduction of total financial support for these programs to some optimal level, correlated with increases in the output of U.S. medical schools and/or a decrease in FMG influx would seem to be a desirable corresponding action.

ACCESSIBILITY OF MEDICAL CARE

Many experts believe that the "medical manpower crisis" in the United States is as much or more due to a shortage of services as a shortage of physicians. They think that if the available physicians were better distributed geographically (more in rural areas) and in terms of specialty (more in primary care), America's health care needs could be met. If it is true that FMGs are not helping to solve the problem of maldistribution

of health care services, then relevant policy options include providing incentives for FMGs to move from urban to rural areas and from other specialties to primary care. To direct such programs at FMGs alone, however, would seem politically unsound. Any loan forgiveness or financial incentives program for FMGs would have to be a part of a larger program directed at all medical graduates in this country.

Financial Aid

Special stipulations might be written into any legislation providing loans, scholarships, or other stipends to FMGs. For example, a provision for loan-forgiveness might be extended to FMGs participating in language, orientation, and review programs if they choose careers in selected specialties or in selected geographical areas. This may prove to be an important lever, particularly if some existing proposals to replace Federal formula grant support of training institutions and programs with Federally guaranteed or insured student loan programs are implemented. Another alternative might be to make the choice of selected specialties or areas a mandatory criterion for financial aid. This would have to be carefully formulated as an incentive and would have to be compatible with aid to U.S. students, so that it would not be interpreted as a means of coercing poorer foreign nationals into undesirable positions not filled by U.S. graduates.

A study of post-World War II State-sponsored programs for USMGs which provided loan-forgiveness for practice in shortage areas showed that only one (Kentucky's) actually succeeded (19). The majority of beneficiaries of these programs chose to buy their way out, while a few defaulted. The study did not indicate whether those who did go to shortage areas remained there. The implications of this for similar programs for FMGs should not be overlooked in any consideration of this alternative.

Other economic incentives, such as higher pay and more fringe benefits for FMGs working in certain areas or specialties, might also be considered. This action alternative would run directly counter to those which are designed to reduce the incentives for FMGs to come to the United States, however, and cannot reasonably be extended only to FMGs in any case.

Expand COTRANS

Expansion of the Coordinated Transfer Application System (COTRANS) has been suggested as a means for increasing the numbers of U.S. graduates and thus increasing physician supply. Over 560 U.S. students from foreign schools have been placed in U.S. schools through COTRANS, but eligible students abroad are

now unable to find a vacancy in a domestic school for their third and fourth years. This is due in part to the number of transfers of students from U.S. schools (e.g., from other degree programs or two-year medical schools). Thus, the number of places open to COTRANS applicants are limited. Regardless of whether such places are expanded significantly, however, U.S. citizens studying abroad would benefit from an expansion of the COTRANS program to include a centralized matching service which could provide information about applications, vacancies, interviews, and perhaps a single fee for transfer applications. *Intensive review courses could be developed which would assist the U.S. student in preparing for Part I of the National Board Examination* and facilitate his entry into the COTRANS program if vacancies should become available for those students. Such a program should be considered only as a short-term measure to facilitate the early return of the numbers of U.S. citizens abroad at present; it should not be developed as a continuing route which would, in fact, circumvent the admission criteria and basic science curricula of accredited U.S. schools.

One advantage of this action alternative is that it provides for an increase in the output of domestic medical schools on the basis of a minimal investment. Another advantage is that transferees will in all likelihood be more easily absorbed into the American medical system after graduation than either U.S.-born FMGs or foreign-born FMGs. A major limiting factor is the number of transferees who can be accommodated in third and fourth year programs in medical schools without seriously overtaxing the resources primarily planned for the regular four-year student body. Unlike the teaching facilities needed for pre-clinical instruction, however, clinical teaching facilities in the United States can be expanded with relative ease through the use of community hospitals. Many medical schools opened since the late 1960s have already demonstrated this. Taking the first two years of medical school abroad in lieu of preclinical medical education in the United States raises serious considerations. If the Federal Government should support such a program, it would actually be an encouragement to U.S. citizens to go abroad for the first two years of their education to schools where administrative procedures and course content are not equivalent to those in U.S. medical schools.

COST OF MEDICAL CARE

Some of the proposed action alternatives to upgrade FMG skills and increase educational and professional requirements in certain programs would decrease the number of FMGs working for lower wages in situations which are not now attractive to USMGs. Proposed special training programs for FMGs would also add to medical education costs. It is appropriate to consider the possible costs involved in three potential action alternatives:

- 1) replacing FMGs entering the graduate medical education process by an equivalent number of domestically produced physicians;
- 2) expanding the COTRANS program to replace a given annual influx of foreign-born FMGs by an equivalent number of U.S.-born students in foreign medical schools; and
- 3) providing training programs for FMGs in the United States which consist of English language, clinical clerkship, and orientation to the U.S. health care system and culture.

It would perhaps be equally appropriate to estimate the cost of replacing FMGs with psychiatric social workers, psychologists, or other professionals in State mental hospitals. There is also a need for cost-benefit studies and task analysis to determine the medical care impact and economic effects of replacing FMGs with physician extenders or other mid-level personnel in situations where this may be possible. At this time, however, only cost estimates related to the three action alternatives noted above will be presented.

Expand Domestic Output

The first program involves a scheduled expansion of domestic productive capacity, the incremental rate of output from which is assumed to equal the decrement in the rate of admission of FMGs into domestic graduate medical education programs. It is assumed that this expansion of capacity will be accomplished by increasing the number of four-year medical schools.

In reviewing the experience of developing medical schools during the decade of the 1960s, Smythe suggests that the expected duration of time from initial authorization of a new medical school to the graduation of the first class of physicians is nine years (20). The number graduated that first year averages 35 percent of the projected first-year class size. The minimal elapsed time between authorization of a new school and its

granting of the first M.D. degree is eight years, including four years of planning and implementation before the first class is enrolled.

In projecting the possible course of events, the expansion of domestic capacity is assumed to conform to the experience of the group of institutions classified as developing four-year schools without major commitments to education of other health professionals and making little use of existing facilities (20, 21). In this way, projections are made on the basis of the experience of "regular" medical schools starting essentially from scratch, and the analysis is confined to a sample of institutions having an homogeneous pattern of growth. The experience of these institutions during their development was as follows. Typically, four years passed between authorization of the school and admission of the first class. The average projected first-year class size was 90 students. For these institutions, basic science facilities averaging 360,000 square feet, clinical facilities averaging 460,000 square feet, and 380 in patient beds were planned.

Costs associated with medical school construction were reported to average \$52 per square foot over the decade of the 1960s, while start-up costs averaged \$80,000 for the first year in the type of school under consideration (20). Using these figures with the pattern discussed in the preceding paragraphs, one can project a capital cost of some \$43 million and an accumulated operating expense of some \$34 million before a newly created institution reaches its planned capacity output of 90 doctors per year. This rate of output can then be sustained for an annual operating budget of some \$4 million. All these costs are, of course, measured in 1960-decade dollars.

If it is desired eventually to replace a yearly influx of 3,000 FMGs with an equivalent number of USMGs by expanding domestic capacity through the financing of new medical schools of the type discussed above, the construction of some 34 such institutions would be required. The cost of such an undertaking might be calculated as follows. Thirty-four medical schools at \$43 million each in the 1960s is a total capital outlay of \$1.46 billion 1960-decade dollars. If all these institutions were authorized at the same time, a total of \$1.16 billion 1960-decade dollars in operating expenses would be accumulated before the desired equilibrium

output of 3,000 M.D.s per year were obtained twelve years later. If this program were started in 1974, say, then a total of \$2.62 billion 1960-decade dollars would be spent by 1986. At the current rate of inflation, however, a 1960-decade dollar will be worth approximately 1.46 1974 dollars, so that roughly \$3.8 billion of today's dollars would be dispersed over that period of time.

Such a program will result in increasing the number of four-year medical schools by more than one-quarter of the current number. More significantly, increasing the number of fully activated four-year schools by 34 between 1974 and 1986 would require that the rate of expansion of medical schools over the period more than double that of the period 1959-71, in which 16 new four-year institutions were authorized and admitted their first classes of medical students. Consequently, if this underlying rate of expansion is to be maintained, then accomplishing the objective of replacing 3,000 FMGs per year by 1986 while maintaining the overall rate of growth of the number of physicians in practice requires that the rate of expansion of medical schools in the next decade be more than triple that of the previous one.

A tripling of the rate of construction of new medical schools might strain the system's ability to accommodate an increase in the demand for the specialized resources involved without undesirable side effects. Moreover, if such a program were attempted over the next twelve years, it would no doubt cause a great deal of inflation in the labor markets for faculty and support personnel, with the result that the realized cost might be considerably more than the estimated \$3.8 billion.

Expand COTRANS

The second program involves expanding capacity in the last two years of medical school — the clinical science-intensive programs — to accommodate an increase in admissions of COTRANS transfer students. It was noted earlier that at the present time many potential COTRANS transfers are not being accepted by domestic programs because of inadequate capacity in the last two years. Significant expansion of COTRANS must be accompanied by expansion of both clinical facilities and personnel under the existing technology of medical education which emphasizes the use of medical school facilities for clinical training.

Smythe notes an apparent shift in this trend among the newest medical schools, in that less emphasis is being placed on construction of university hospitals

(20). This could mark a new focus on a decentralized or modular approach to the last two years of undergraduate medical education, with existing community facilities being utilized more intensively. If this is the case, capital expenditures to expand the last two years might be significantly less than otherwise, with the primary impact being an increase in hospital and/or medical school operating costs.

Several statistical analyses of hospital costs suggest that the impact of undergraduate medical education on expenses of affiliated hospitals is very small or zero (22, 23). The interpretation of these studies, however, is not that undergraduate clinical education in the hospital context is costless, but that typically the accounting expense is borne by the affiliated medical school. Furthermore, the fact that house staff generally bear the major instructional responsibilities in these settings suggests that some of the expenses of internship and residency programs in affiliated hospitals may be a joint cost with that of undergraduate educational activities.

In any case, it is likely that there are enough existing hospitals with the requisite properties to afford a significant expansion of positions in the last two or clinical years of undergraduate medical education with minimal investment in new plant. These requisites are (1) an existing graduate medical education program and (2) organizational and logistical conditions amenable to affiliation with a medical school. Where these circumstances exist, it is reasonable to assume that the desired expansion could be induced by offering capitation grants of an appropriate magnitude to selected medical schools. Such grants would provide an incentive to selected medical schools to design and implement the necessary administrative and instructional framework involving existing hospital organizations, personnel, and facilities in their clinical science programs and to accept students in addition to those from their own basic science programs.

Orientation and Review Programs

The third alternative consists of requiring FMGs, prior to their entering the graduate medical education process, to undergo English language and basic clinical science review as well as orientation to the social, cultural, and institutional setting of American medical education and health care delivery. Although recommended by the Panel on Foreign Medical Graduates of the Health Manpower Commission (2), a coordinated program of this type has yet to be implemented. Consequently, estimates of the cost can be based only on conjecture rather than historical experience.

Assuming that such a program is university-based allows one to estimate its potential cost by assuming that it will be offered in the regular curriculum of the medical school at a fixed rate per credit-hour, and that it will require full-time participation of the student for a year's time. If the charge for such tuition then is the same as that for regular tuition in private four-year medical schools, it will average some \$3,000 per year per student. Such a fee is representative of the annual charge for tuition in private medical schools and thus is not as heavily subsidized as that in State or public institutions; it is not representative, however, of the full cost of tuition borne by the student, the institution, and its benefactors.

Several different examples of such a review/orientation are currently being offered. A number of English Language Study Summer Programs conducted

by universities offer intensive language review. Such programs are generally 8 to 12 weeks in duration and average \$400 for tuition.

There are also at least four courses currently offered for ECFMG examinees. These include a ten-week course at the University of Miami School of Medicine, which is taught in Spanish; a ten-week course at St. Barnabas Hospital in Livingston, New Jersey; and a two-part course at French and Polyclinic Hospital in New York City consisting of a six-week basic science review and a six-week general medical review. An even shorter (8-day) course is offered at Queens Hospital Center in New York. The current cost per student of the University of Miami course is \$600, compared to \$400 for the French/Polyclinic general medical review, \$300 for the St. Barnabas course, and \$100 for the Queens course.

CONCLUSION

The uncertainty which surrounds the role of the FMG in the U.S. health care system reflects in part a lack of consensus in the United States about health manpower development in general and physician education in particular. As long as foreign medical graduates are used to ameliorate a perceived shortage of medical manpower, the United States will continue to be dependent on an uncontrollable and unpredictable source of supply. Effective policies and planning for both the absolute number of U.S. physicians and their distribution, both geographically and by specialty, will be hampered by continued reliance on foreign resources. Hospital staffing shortages are a critical factor in the current situation. As long as these shortages can be met by the use of FMGs, there is little impetus to reassess the role of the physician in the hospital or to re-evaluate the service and educational functions of the internship and residency. Up to now, the United States has avoided many educational and health manpower problems through the increasing use of foreign physicians. Continued reliance on this source of medical manpower tends to delay proper development of long-range goals, policies, and programs for United States medical education capacity, and for linking these with goals, policies, and programs for the organization

and financing of health care services delivery in predictable, cost-effective ways.

The action alternatives mentioned above are intended to suggest possible ways in which our national goals with regard to health care can be implemented and a coordinated policy for FMGs can be achieved. This report has not questioned the assumption that there is a current shortage of physicians (or perhaps more appropriately of health care personnel) in the United States, although this assumption is open to attack. This report also has not questioned the assumption that fully licensed USMGs are a reasonable standard against which to assess the performance of FMGs. Both these assumptions require serious consideration in any extensive health manpower planning efforts, as do assessments of the current health care needs of different types of Americans and the impact of advances in medical technology. Although these considerations all lie outside the scope of this report, they demonstrate the complexity of the FMG issue and serve to illustrate its involvement in the broader problems of quality, cost, and accessibility of health care to the citizens of the United States.

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APPENDIX



FOREIGN MEDICAL GRADUATE IMMIGRATION,
EDUCATION, AND CAREER PATHWAYS

The chart designed for Appendix A depicts the currently existing sources of information and how they might be tapped as a means of monitoring the passage of FMGs into, through, and out of the medical education and health care system in the United States. As indicated in the legend, some sources afford only partial coverage of the FMG population. Even data sources which seem to offer complete coverage may still not dovetail enough to ensure that all FMGs moving through the system will be tracked continually. Furthermore, they may have data needs of their own which are not relevant to or compatible with the needs of other users.

The flow chart has five basic paths from start to final exit. The "A" path is used by those FMGs who have a foreign medical degree, pass the ECFMG examination, and obtain a limited license in the United States. The "B" path is taken by those FMGs who meet the first two requirements of the "A" path but who do not obtain a license of any sort. The "C" and "D" paths are for those FMGs who receive a foreign medical degree but who fail or do not take the ECFMG examination. If at some point such an FMG obtains a limited license, he might move along the "C" path; otherwise, he remains on the "D" path. There is a potential connection between the "C" path and the "A/B" paths, should the FMG ever successfully complete the ECFMG examination and become certified. Finally, the "E" path is followed primarily by those FMGs on the "A" track who obtain a full and unrestricted license to practice medicine in the United States.

In addition, at least two variant paths can be traced. These involve the special programs for U.S. citizens studying medicine abroad who enter either COTRANS or the "Fifth Pathway" prior to and instead of obtaining a foreign medical degree. Obviously, these U.S. citizens circumvent the immigration step as well as the ECFMG examination.

One problem in tracking FMGs through either the medical education or health care system has been that FMGs in essence could be lost as they moved out of the purview of the Immigration and Naturalization Service (11) and into activities monitored by the Association of

American Medical Colleges (AAMC) (1), the American Hospital Association (AHA) (2), the American Medical Association (AMA) (3), or other government agencies (9). This may be ameliorated somewhat by new regulations regarding the assignment of Social Security numbers to all aliens entering as or changing status to permanent resident. This would involve the Social Security Administration (Department of Health, Education, and Welfare) at the point of immigration (but is not shown at present on the diagram).

Certain other data sources are, at this writing, only potential. These include professional or educational organizations such as the American Public Health Association (APHA) and the American Psychiatric Association (APA), the American Board of Medical Specialties and the individual specialty boards, the Institute of International Education (IIE), and various student and FMG organizations. The other major potential source of data is the Federal Government itself, including the Bureau of the Census (Department of Commerce), the Internal Revenue Service (Department of the Treasury), the Social Security Administration (SSA) and Health Resources Administration (Department of Health, Education, and Welfare), and the Department of State. International organizations such as the Pan American Health Organization (PAHO), World Health Organization (WHO), Organization for Economic Cooperation and Development (OECD), the World Federation of Associations of Medical Schools, and Unesco are also potential sources of information on such topics as enrollment in medical schools, migration patterns of health professionals, and utilization of FMG returnees to the home country.

At the present time, data of an informal or anecdotal nature is available from the APA and the American Board of Medical Specialties. Also, UNESCO will be the most comprehensive source of information on U.S. citizens studying medicine abroad upon completion of a worldwide survey of medical schools in 1974, with the Western Hemisphere data being available through PAHO. Finally, WHO will eventually be a primary source of data on the international movement of physicians and nurses.

The sources of data on FMGs as they enter or leave one or another activity along one of the paths are shown by numbers enclosed in circles (for relatively complete coverage) or in triangles (for only partial coverage). A lack of sources on other hospital training and other health activity is notable. The paucity of final outcome (exit) data sources is striking. The most serious problem is the absence of any data on FMGs who emigrate from this country.

Not all the data sources for any one activity are necessarily shown; generally, only those with the most comprehensive coverage or those serving as the primary source are noted. In cases where only partial coverage by several sources is indicated, it should not be assumed that the coverage is additive and therefore more or less complete. Sources which might provide (or have provided in the past) one-time-only information, either statistical or anecdotal, are also not shown, although

efforts might be undertaken to cultivate such resources for the future.

In summary, the flow chart illustrates the complexity of the FMG component of medical education and health care delivery in the United States at the moment. At least two points (shown in diamonds) are pivotal in determining the tracks for FMGs — obtaining ECFMG certification and securing limited or full licensure — and these tend to complicate the FMG picture relative to that for USMGs. Movement within immigrant and nonimmigrant visa categories makes the problem more involved, as does emigration as one possible, but unknown, outcome. The FMG component of U.S. physician manpower supply and utilization will remain the weakest input factor in the analysis and planning for health and health manpower, until a more coordinated and comprehensive data gathering and reporting system is established.

DATA SOURCES

- | | |
|---|---|
| <ul style="list-style-type: none"> ① Association of American Medical Colleges (AAMC) ② American Hospital Association (AHA) ③ American Medical Association (AMA) ④ American Board of Medical Specialties, and the individual specialty boards ⑤ Federation of State Medical Boards, and the individual State licensing boards ⑥ Commission on Foreign Medical Graduates (CFMG) ⑦ Educational Council on Foreign Medical Graduates (ECFMG) | <ul style="list-style-type: none"> ⑧ United Nations Educational, Scientific, and Cultural Organization (Unesco) ⑨ Federal or other government agencies not otherwise listed ⑩ Department of Labor ⑪ Immigration and Naturalization Service, Department of Justice |
|---|---|

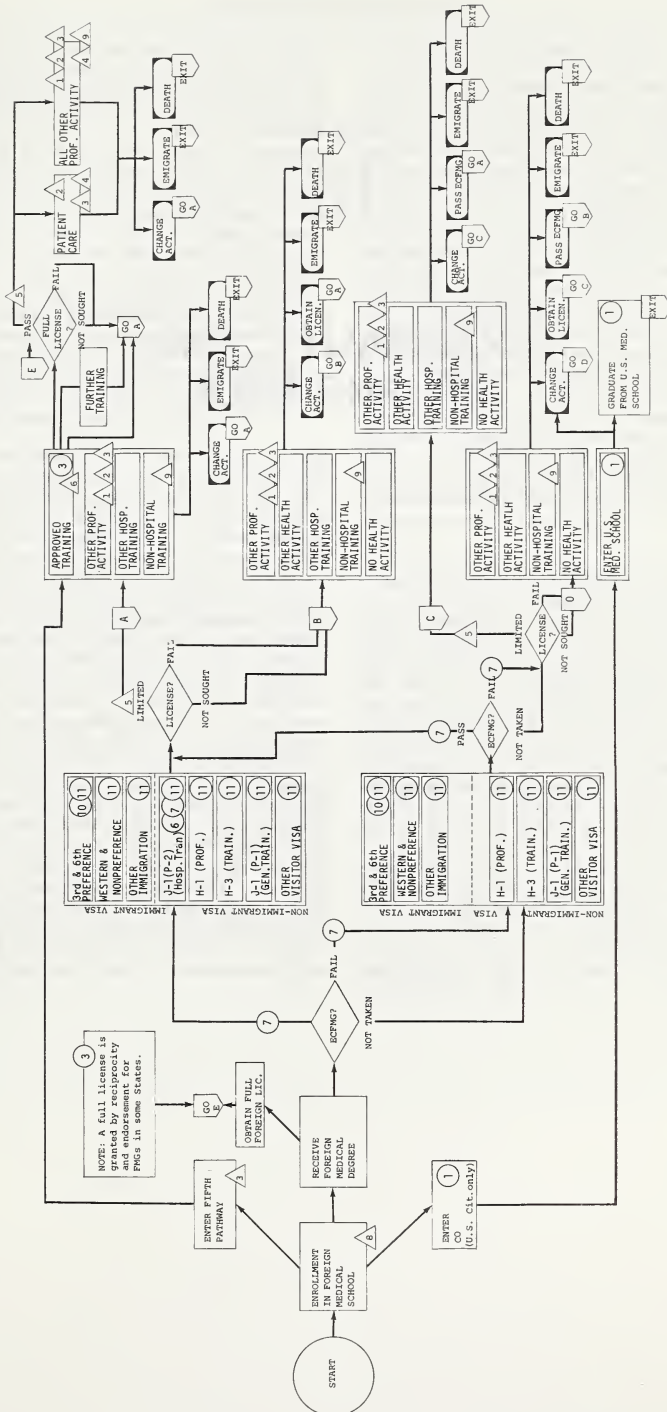
Partial coverage

Complete Coverage



ACTIVITIES

Patient Care	=	All activities of physicians involving direct patient care.
Other Professional Activity	=	Activities not involving direct patient care but requiring a medical degree. For example: administration, teaching, research, physicians with insurance carriers, pharmaceutical companies, corporations, voluntary organizations, medical societies, associations, etc.
Other Health Activity	=	Employment in the health field not requiring a medical degree: laboratory technicians, physician assistants, technologists, etc.
Approved Training	=	Internships and residencies approved by the American Medical Association
Other Hospital Training	=	Non-AMA-approved internships and residencies, externships, fellowships, hospital-based research, and other training programs
Non-Hospital Training	=	Research training in institutes, public or private organizations, laboratories, educational and other non-hospital settings
No Health Activity	=	Employment or non-employment activity for which no medical degree or health related experience is necessary
COTRANS	=	Coordinated Transfer Application System enabling U.S. citizens in foreign medical schools to transfer with advanced standing to an American medical school
Fifth Pathway	=	One year of approved clinical training in the United States to be substituted for internship/social service requirement of some foreign medical degrees



APPENDIX

B

EXTERNALITY AND
THE FMG ISSUE

EXTERNALITY AND THE FMG ISSUE

The purpose of this brief note is to suggest a framework for addressing the various issues surrounding foreign medical graduates, especially those issues involving questions about the proper role of the various levels of government in dealing with particular problems. The approach is based on the concept of externality. Externalities, or "neighborhood effects" as they are sometimes called, are said to be present when individual decision-making has extra-individual effects. The consequence of externality is that individual decisions, when viewed from some collective or social perspective, result in inefficient use of resources. In other words, the presence of externality characterizes a situation in which individual optimizing does not result in global or system-wide optimality because the interdependence of individual behavior is not taken into account in individual decision processes. To deal with the perverse consequences of externality, decisions must somehow be coordinated at the system-wide level.

In the present context, the individual decision-makers are the States which have control over the composition and magnitude of resources devoted to support of undergraduate medical education. In the context of a Federal system, the States generally determine the rates of output of physicians by virtue of their having regulatory and budgetary control over much of higher education. The global or system-wide perspective is that of the Federal Government which is concerned with the aggregate rate of output of physicians and also, perhaps, with their spatial distribution. In this context, externalities arise by virtue of the interstate migration of physicians between the undergraduate and graduate phases of their medical education. Because of this migration, many States are net exporters of physicians but are not compensated by importer States for the costs of producing physicians from which they realize no benefits. The absence of a market in which individual States are forced to confront the costs and benefits associated with the interstate flows of undergraduate doctors implies that their separate decisions will generate a different solution for the domestic production of physicians than would arise if these decisions were coordinated in such a way that the costs and benefits were reflected in the State's decisions regarding support of undergraduate medical education.

The effect of externality on the total domestic production of physicians can be deduced in a straightforward way if one assumes that, in allocating their budgets toward the alternative modes of public expenditures, each State achieves a rate of undergraduate medical education at which the marginal cost equals the perceived marginal benefit. That is, each State allocates funds to undergraduate medical education until the incremental cost of another doctor equals the incremental benefit which the State's inhabitants would gain from that doctor. Under these conditions, States which experience a net outflow of undergraduate doctors perceive their production of physicians being subjected to a tax which has the effect of reducing the benefit expected to accrue to the States' inhabitants from each physician produced. Compared to a State which realizes net migration of zero, States which are net exporters of undergraduate doctors to other States perceive lower marginal benefits relative to the marginal costs of production, with the result that they will produce fewer physicians. In other words, because such a tax on their output lowers the net marginal benefit derived from producing physicians, States which are net exporters will produce fewer than otherwise.

States which are net importers of undergraduate doctors are affected favorably by the interstate migration of physicians; in their case, the impact of externality is viewed as that of a lump-sum subsidy, or a "grant" from the net exporter States of the federation. The effect of such subsidies on decisions of net importer States will depend on the rates of change of the marginal benefits as they consider the production of more undergraduate doctors. If the marginal benefits are constant, i.e., if each additional physician is associated with same addition to the total benefit as from the preceding one, then it can be seen that the solution for the output of physicians is not distributed by a lump-sum subsidy. If, on the other hand, marginal benefits decline with the addition of physicians such that incremental additions from the State's own educational sector add less to the total benefit than those obtained in "grants" from other States, then one can see that the conditions for optimal output will be satisfied with a lesser magnitude of a State's own production than otherwise.

From the preceding, it is clear that net exporter States unambiguously produce fewer physicians than otherwise, while net importer States do not produce more. In general, then, one can conclude that the aggregate or total domestic output of physicians is diminished in the presence of the type of externality under discussion. Empirically, there is much anecdotal evidence supporting the hypothesis that the free interstate migration of undergraduate doctors does in fact have a negative effect on the capacity-determination decisions of exporter States. There are concrete signs, however, that current capacity, relative to the demand for education, is generally insufficient. That is, given current prices for the services of physicians and the current costs of becoming a practicing physician, there is excess domestic demand for undergraduate medical education. This is manifested by the current excess of qualified applicants over matriculants in medical schools, and the consumption of undergraduate medical education abroad by U.S. citizens. Thus, the States which claim the responsibility for determining the supply of education under the Federal system have created — in their failure to respond to the obvious indications of excess demand — a bottleneck in the first phase of the process through which individuals pass to become practicing physicians.

In other words, the problem of the shortage of undergraduate medical education capacity can be traced to an inappropriate supply response on the part of the States. It is inappropriate, however, only from a more general perspective, and not from the perspective of an individual State. Just as an individual whose actions generate extra-individual consequences can regard his behavior as appropriate from his own viewpoint, so can the States appropriately disregard the consequences of their own decisions for other States, even though a community of interest in coordinated decision-making may exist. This community of interest, however, justifies coordination of decision-making at a higher level of organization — just as it does at the State level for decisions respecting the supply of education for its individual citizens. This is where the Federal Government comes in. The rationale for Federal pursuit of a physician policy is the same as that for the States assuming responsibility for functions which local markets perform inadequately.

It is, therefore, at the Federal level of decision that the shortage of undergraduate medical educational capacity is an issue in which foreign medical graduates are involved. The influx of FMGs into the physician training process serves to augment the diminished rate of passage of domestic undergraduate doctors to grad-

uate education resulting from the bottlenecks at the State level. Evidently, the problem is: should the issue of the undergraduate doctor shortage continue to be resolved in favor of FMGs, or should it be resolved by Federal intervention to eliminate the bottlenecks in undergraduate medical education at the State level?

Consideration of FMGs as a potential solution to this problem introduces two additional issues which may or may not be relevant at the Federal level of decision. These are the "brain drain" and "quality of care" issues. We must ask, therefore, for what reasons and to what extent are these issues also relevant at the Federal level?

In terms of the decision processes involved, there are potentially three levels or strata of concern in the overall problem. First, there are the decision processes of the individual States which determine their investments in undergraduate physician education. Second, there is the perspective of the Federal Government which views the results of the decisions made at the State level and the flows of physician manpower among the States. Third, perhaps, is the perspective of the world, from which one can view the decisions made by the nations of the world and the flows of physician manpower among them. From this frame of reference, one can draw several analogies:

1. A State's (e.g., California's) view of itself as a net importer of undergraduate physicians from other States is analogous to the United States' view of itself as a net importer of undergraduate physicians from other countries. Both situations are characterized by shortages supplemented by importation.
2. A possible world view of the United States as a net importer of physicians from other countries is analogous to the United States' view of California as a net importer of physicians from other States. Both cases are characterized by inappropriate internal prices leading to non-optimal internal production and importation levels.
3. A possible world view of itself is analogous to the U.S. view of itself: this case is characterized by significant externalities reflected in inappropriate rates of exchange between individual decision-making components.

In general, therefore, the "brain drain" phenomenon can be seen to exist at the interstate as well as at the international level. But while it is clearly within the appropriate realm of Federal concern at the interstate level, whether or not its international manifestations

should concern the United States is subject to our own discretion; in the absence of an international federation or agreement, there is no compulsion except our own self-interest to consider in formulating explicit policy with respect to FMGs.

Consider now the problem of centralized price control as a means of "internalizing" the externalities that exist between independent decision-making units. According to the analogies drawn above, the world problem of price determination would be identical to that of the Federal problem of determining the appropriate rates of exchange between the States; and the Federal problem of determining the appropriate importation of FMGs becomes identical to that of California in making decisions in the context of a Federal system. While there is a price paid for each FMG we import, its magnitude eludes us because there is no explicit world mechanism or fully coordinated Federal information system which maps from its multi-dimensional domain of definition onto the real line where we can observe it. The Federal role with respect to the States in this regard is to install a mechanism which makes the total cost of importing both USMGs and FMGs a direct function of the quantities imported by each State. From the perspective that views the hierarchical State-Federal decision system as appropriate, implementation of such a mechanism is a sufficient policy response to the dual FMG — undergraduate M.D. shortage issue. The States are then confronted with the socially correct prices and are left free to determine their own physician education policies to satisfy the collective demands of their respective citizens.

Likewise, the same perspective would disallow "quality of care" in relation to FMGs as an appropriate issue for Federal concern as long as regulation or control of quality is reserved for the States under the Federal system. If, however, external effects are associated with the States' adopting heterogeneous quality standards, justification for Federal intervention is evident. Whether or not such externalities are present can be determined independent of the FMG issue. The existence of differential standards respecting quality of care between States might lead to externalities in at least the following ways. First, there is the contagious disease problem wherein it is clear that the actions taken by one State will have consequences for the inhabitants of neighboring States. The significance of this problem with regard to FMGs is not clear, however. Second, there may be situations where substandard medical care in one State will result in other States

bearing the burden if residents of the former become welfare recipients in the latter as a direct consequence of their receiving improper or inadequate treatment, becoming disabled, and migrating to States with higher welfare payments.

In addition to the externality argument, an argument for uniform standards of care might be put forward on the grounds that the States are no longer the appropriate unit for setting standards of this type. Essentially, the economic value of standards can be assessed as the reduction in decision costs that are afforded to consumers who would otherwise have to resolve a great deal of uncertainty about the nature of or consequences of consuming goods and services before making a choice. This economic value of standards to the general population is inversely related to the rate of mobility of the population between States when all the States have different standards expressed in different terms. As the population becomes more mobile, it is conceivable that a point would be reached where the benefit of establishing uniform standards would outweigh the costs associated with removing freedom to set standards from the discretion of the States.

In general, however, a Federal mechanism designed to eliminate the inefficiency or externalities associated with the interstate "brain drain" would also tend to be ameliorative with regard to the FMG problem. Under such a mechanism, the price of importing FMGs would have to be set by the Federal authorities at some level greater than it is now, which is approximately zero. This would, therefore, raise the price of FMGs relative to domestic medical graduates, and would tend to have two effects. First, the States would tend to respond by increasing domestic production and reducing importation of FMGs. Second, the reduction of importation would undoubtedly be at the expense of the less-well prepared FMGs, resulting in an increase in the average level of "quality" of FMGs admitted into the domestic graduate medical education process.

The above few paragraphs focused on centralized price-setting as a means of dealing with the problem of externality between individual decision-making entities. By such a method, which could be physically imposed as a system of tariffs, a centralized authority extracts from the net importer or externally affected States compensation on behalf of exporter States which are unwilling or unable to assert property rights in the intellectual capital of individuals toward whose education they have contributed resources. It is clear, however, that resort to a central authority to establish

property rights is unnecessary if exporter States either unilaterally or in coalitions assert property rights in emigrating physicians. Within the United States, the mechanism to be employed — either an interstate tariff system administered by the Federal Government or contractual agreements between States and medical students — is subject to choice. On the other hand, if the United States adopts a policy — implicitly or

explicitly — of relying on importation of FMGs as a cure for its physician production problems, then other countries may begin to assert property rights in the physicians which they produce, with perverse consequences for domestic expectations. Inquiry into the probability of such retaliation is beyond the scope of this note.

Appendix Table 1
 FOREIGN PHYSICIANS AND SURGEONS ADMITTED AS IMMIGRANTS, BY REGION AND COUNTRY
 OF LAST PERMANENT RESIDENCE:
 1966, 1969, and 1972

Region and country of last permanent residence	Fiscal year		
	1966	1969	1972
Grand total	2,552	2,756	7,143
Europe	667	579	911
Austria	16	49	15
Belgium	17	6	14
Czechoslovakia	5	10	24
Germany	81	52	72
Greece	38	36	64
Ireland	22	18	26
Italy	43	51	32
Poland	22	21	25
Spain	53	51	58
Sweden	20	8	17
Switzerland	27	12	25
Turkey	57	42	50
United Kingdom	187	140	364
Yugoslavia	12	36	33
Other	67	47	92
Americas	1,210	587	959
Argentina	115	42	45
Bolivia	19	13	23
Brazil	33	7	12
Canada	393	236	439
Chile	11	8	13
Colombia	80	47	82
Cuba	150	54	55
Dominican Republic	—	21	40
Ecuador	23	29	23
Guatemala	8	8	13
Haiti	29	27	21
Jamaica	15	14	18
Peru	46	14	36
Other	288	67	139
Asia	588	1,435	4,996
Burma	5	24	28
China (Mainland)	5	13	68
Hong Kong	26	39	45
India	40	129	1,513
Indonesia	—	28	27
Iran	78	99	459
Iraq	5	3	33
Israel	31	30	62
Japan	31	28	61
Korea	35	128	768
Lebanon	14	30	53
Pakistan	11	22	201
Philippines	259	785	782
Syria	9	8	19
Thailand	11	12	268
Taiwan	11	27	470
Other	17	30	139

(Continued)

Appendix Table 1
(Continued)

Region and country of last permanent residence	Fiscal year		
	1966	1969	1972
Africa	60	137	222
Egypt	23	96	63
Kenya	1	6	13
Libya	1	3	18
Nigeria	2	2	21
South Africa	15	8	36
Tanzania	—	2	19
Uganda	—	—	24
Other	18	20	28
Oceania	24	18	55
Australia	21	14	43
New Zealand	2	4	12
Other	1	—	—
Unknown	3	0	0

Source: *Scientists, Engineers, and Physicians from Abroad*, FY 1966 and 1967, NSF 69-10, p. 12, Washington: Government Printing Office, 1969; *Annual Indicator of Immigration to the United States of Aliens in Professional and Related Occupations, Fiscal Year 1969*, Washington, D.C., Department of Justice, June 1970; National Science Foundation, 1972 Immigration Tables D1 and D2.

Appendix Table 2
FOREIGN PHYSICIANS AND SURGEONS ADMITTED AS IMMIGRANTS BY REGION AND COUNTRY
OF BIRTH AND REGION AND COUNTRY OF LAST PERMANENT RESIDENCE:
1972

Region and country	Country of birth	Country of last permanent residence	Same country of birth and last permanent residence	Region and country	Country of birth	Country of last permanent residence	Same country of birth and last permanent residence
Grand total	7,143	7,143	5,603				
Europe	654	911	436	Asia	5,558	4,996	4,434
Austria	6	15	3	Burma	45	28	25
Belgium	14	14	11	Ceylon	53	46	43
Czechoslovakia	34	24	22	China(Mainland)	274	68	60
France	9	22	5	Hong Kong	16	45	6
Germany	54	72	44	India	1,802	1,513	1,410
Greece	76	64	60	Indonesia	47	27	25
Ireland	19	26	17	Iran	485	459	455
Italy	27	32	18	Iraq	54	33	31
Netherlands	7	11	4	Israel	38	62	27
Poland	46	25	23	Japan	76	61	45
Portugal	13	13	10	Jordan	16	14	6
Romania	47	19	19	Korea	810	768	749
Spain	47	58	38	Lebanon	28	53	25
Sweden	10	17	9	Malaysia	21	14	8
Switzerland	8	25	7	Pakistan	260	201	130
Turkey	51	50	43	Philippines	831	782	770
United Kingdom	77	364	50	Saudi Arabia	0	21	0
Yugoslavia	46	33	32	Syria	29	19	16
Other	63	27	21	Thailand	275	268	265
				Taiwan	333	470	315
Americas	626	959	550	Other	65	44	23
Argentina	48	45	39				
Bolivia	24	23	20	Africa	259	222	146
Brazil	12	12	12	Egypt	115	63	57
Canada	103	439	100	Kenya	20	13	9
Chile	11	13	10	Libya	1	18	0
Colombia	80	82	72	Nigeria	24	21	16
Cuba	73	55	54	South Africa	42	36	32
Dominican Republic	39	40	39	Tanzania	21	19	14
Ecuador	25	23	22	Uganda	10	24	4
Guatemala	11	13	11	Other	26	28	14
Haiti	28	21	20				
Jamaica	5	18	5	Oceania	46	55	37
Mexico	53	54	53	Australia	36	43	29
Peru	40	36	34	New Zealand	10	12	8
Other	74	85	59				

Source: National Science Foundation, 1972 Immigration Tables D1 and D2.

Appendix Table 3
 FOREIGN PHYSICIANS AND SURGEONS ADMITTED AS NONIMMIGRANTS ¹ BY REGION
 AND COUNTRY OF BIRTH AND REGION AND COUNTRY OF LAST PERMANENT RESIDENCE:
 1972

Region and country	Country of birth	Country of last permanent residence	Same country of birth and last permanent residence	Region and country	Country of birth	Country of last permanent residence	Same country of birth and last permanent residence
Grand total	4,273	4,273	3,925	Asia	1,976	1,936	1,807
Europe	1,046	1,039	935	Burma	3	2	2
Austria	43	39	38	Ceylon	75	74	73
Belgium	21	22	19	China (Mainland)	50	23	20
Czechoslovakia	12	2	2	Hong Kong	19	26	12
France	110	115	107	India	640	620	605
Germany	156	162	150	Indonesia	24	20	20
Greece	44	43	43	Iran	174	175	171
Ireland	76	79	72	Iraq	15	14	11
Italy	66	63	61	Israel	33	49	31
Netherlands	22	25	19	Japan	197	199	194
Poland	21	16	15	Jordan	11	17	8
Portugal	8	6	6	Korea	46	43	43
Romania	17	11	11	Lebanon	35	43	33
Spain	63	61	59	Malaysia	15	15	14
Sweden	35	37	34	Pakistan	106	110	89
Switzerland	41	45	40	Philippines	248	233	233
Turkey	20	20	20	Saudi Arabia	1	2	1
United Kingdom	193	209	166	Syria	43	38	35
Yugoslavia	38	34	34	Taiwan	78	87	75
Other	60	50	39	Thailand	105	106	105
Americas	1,011	1,078	979	Other	58	36	32
Argentina	106	110	103	Unknown	—	4	—
Bolivia	5	5	5	Africa	169	143	138
Brazil	72	73	71	Egypt (UAR)	16	12	12
Canada	181	243	177	Kenya	9	6	5
Chile	43	42	41	Libya	2	2	1
Colombia	63	64	62	Nigeria	47	44	44
Cuba	2	0	0	South Africa	36	32	32
Dominican Republic	42	42	42	Tanzania	10	11	9
Ecuador	13	11	11	Uganda	7	6	5
Guatemala	19	18	18	Other	42	30	30
Haiti	3	1	1	Oceania	71	77	66
Jamaica	17	19	15	Australia	52	61	50
Mexico	167	171	167	New Zealand	16	13	13
Peru	89	89	89	Other	3	3	3
Other	189	190	177				

¹ Exchange visitors and other temporary workers.

Source: Immigration and Naturalization Service National Science Foundation Data Tape, 1972.

Appendix Table 4
FOREIGN MEDICAL GRADUATES¹ IN THE UNITED STATES, BY SPECIALTY AND
MAJOR PROFESSIONAL ACTIVITY:
1970

Specialty	Major professional activity					distribution of total
	Hospital-based practice	Office-based practice	Other activity	Total		
All specialties . . .	28,423	24,490	6,768	59,681 ¹	100.0	
General practice . . .	1,489	5,861	162	7,512	12.6	
Allergy	37	144	46	227	.4	
Cardiovascular disease .	528	476	346	1,350	2.3	
Dermatology	113	309	49	471	.8	
Gastroenterology . . .	180	126	125	431	.8	
Internal medicine . . .	3,576	2,699	619	6,894	11.6	
Pediatrics	1,893	1,439	455	3,787	6.4	
Pediatric allergy . . .	27	42	15	84	.1	
Pediatric cardiology . .	79	40	61	180	.3	
Pulmonary disease . .	361	164	139	664	1.1	
General surgery	3,454	2,013	281	5,748	9.6	
Neurological surgery . .	208	237	44	489	.8	
Obstetrics and gynecology	1,490	1,673	240	3,403	5.7	
Ophthalmology	230	693	97	1,020	1.7	
Orthopedic surgery . .	418	618	51	1,087	1.8	
Otolaryngology	222	489	58	769	1.3	
Plastic surgery	102	131	14	247	.4	
Colon and rectal surgery	21	60	3	84	.1	
Thoracic surgery . . .	181	176	35	392	.7	
Urology	337	461	47	845	1.4	
Aviation medicine . . .	13	14	19	46	— ³	
Anesthesiology	1,387	1,902	276	3,565	6.0	
Child psychiatry . . .	219	194	87	500	.8	
Diagnostic roentgenology	194	140	34	368	.6	
Forensic pathology . .	8	14	25	47	— ³	
Neurology	351	193	169	713	1.2	
Occupational medicine .	10	185	64	259	.4	
Psychiatry	3,020	1,875	693	5,588	9.4	
Pathology	2,076	581	722	3,379	5.7	
General preventive medicine	17	34	56	107	.2	
Physical medicine and rehabilitation	375	115	38	528	.9	
Public health	28	92	205	325	.5	
Radiology	887	558	137	1,582	2.7	
Therapeutic radiology .	118	95	15	228	.4	
Other	1,118	426	1,162	2,706	4.5	
Unspecified	3,656	221	179	4,056	6.8	

¹ Including Canadians.

² Excludes 2,576 inactive and not classified and 1,134 with address unknown.

³ Less than 0.1 percent.

Source: Haug, J. and Martin, B., Foreign Medical Graduates in the United States, 1970, Chicago: American Medical Association, 1971.

Appendix Table 5
 PROPORTION OF FOREIGN MEDICAL GRADUATES IN EACH LOCATION OF THE UNITED STATES,
 BY MAJOR PROFESSIONAL ACTIVITY:
 1970

Location	Number of foreign medical graduates	Percent by major professional activity				
		Office- based practice	Interns and residents	Full- time hospital practice	Other activity	Inactive
Total	55,759 ¹	38	30	19	11	3
Alabama	147	27	23	29	16	5
Alaska	17	76	—	24	—	—
Arizona	282	35	38	17	5	5
Arkansas	25	12	52	32	4	—
California	2,961	55	10	12	15	9
Colorado	258	27	22	21	25	6
Connecticut	1,261	39	36	13	9	3
Delaware	216	37	26	29	6	2
District of Columbia	774	22	42	18	17	1
Florida	1,766	40	22	20	9	10
Georgia	434	39	20	27	13	1
Hawaii	202	53	24	8	9	5
Idaho	11	45	—	45	—	9
Illinois	4,526	40	34	15	8	3
Indiana	471	58	15	16	9	2
Iowa	317	37	34	13	13	3
Kansas	295	21	33	27	17	2
Kentucky	340	24	25	34	16	2
Louisiana	258	9	41	27	21	2
Maine	173	65	2	21	9	3
Maryland	2,243	30	31	21	16	2
Massachusetts	1,958	21	37	20	20	2
Michigan	2,369	32	44	16	7	2
Minnesota	643	29	38	14	16	2
Mississippi	67	31	19	24	19	6
Missouri	978	23	39	21	15	2
Montana	30	57	7	27	10	—
Nebraska	70	21	26	26	24	3
Nevada	14	38	14	29	14	7
New Hampshire	142	68	6	15	8	4
New Jersey	3,213	40	31	20	6	3
New Mexico	127	42	20	21	12	6
New York	15,869	38	30	19	9	3
North Carolina	310	22	25	25	25	4
North Dakota	90	67	6	21	6	1
Ohio	3,498	38	37	16	8	2
Oklahoma	105	18	18	34	27	3
Oregon	141	37	27	16	18	3

(Continued)

Appendix Table 5
(Continued)

Location	Number of foreign medical graduates	Percent by major professional activity				
		Office- based practice	Interns and residents	Full- time hospital practice	Other activity	Inactive
Pennsylvania	2,693	28	41	17	12	2
Rhode Island	491	44	24	22	7	2
South Carolina	97	16	24	40	12	7
South Dakota	70	70	3	21	4	1
Tennessee	306	21	36	25	17	2
Texas	1,539	46	26	14	11	2
Utah	43	2	37	16	37	7
Vermont	71	49	17	20	11	3
Virginia	894	47	21	20	9	3
Washington	427	55	12	13	14	6
West Virginia	462	45	18	27	7	2
Wisconsin	639	42	25	18	12	3
Wyoming	13	77	8	15	—	—
Canal Zone	21	5	33	48	14	—
Puerto Rico	1,311	48	12	31	7	1
Virgin Islands	53	36	—	53	8	4
Pacific Islands	28	50	—	46	—	4

¹ Excluding Canadians, 276 not classified, 204 with APO-FPO address, and 978 with address unknown.

Note: Percents may not add to 100 because of rounding.

Source: Haug, J. and Martin, B., *Foreign Medical Graduates in the United States, 1970*, Chicago: American Medical Association, 1971.

Appendix Table 6
 NUMBER OF RESIDENTS IN AFFILIATED AND NONAFFILIATED HOSPITALS IN THE
 UNITED STATES, BY SPECIALTY AND COUNTRY OF GRADUATION:
 1972

Specialty	Total residents	U.S. and Canadian graduates	Foreign medical graduates	graduates as percent of total residents
Total	44,858	30,418	14,440	32
Affiliated hospitals	40,922	28,720	12,202	30
Anesthesiology	1,867	806	1,061	57
Child psychiatry	419	313	106	25
Colon and rectal surgery	11	4	7	64
Diagnostic radiology	1,631	1,469	162	10
Dermatology	635	577	58	9
Family practice	855	774	81	9
General practice	113	35	78	69
General surgery	6,105	4,033	2,072	34
Internal medicine	7,688	5,168	2,520	33
Neurological surgery	600	484	116	19
Neurology	929	687	242	26
Obstetrics and gynecology	2,730	1,753	977	36
Ophthalmology	1,342	1,242	100	7
Orthopedic surgery	2,030	1,818	212	10
Otolaryngology	946	785	161	17
Pathology	2,329	1,081	1,248	54
Pathology-forensic	6	5	1	17
Pathology-neuropathology	52	37	15	29
Pediatrics	3,050	1,974	1,076	35
Pediatric allergy	109	84	25	23
Pediatric cardiology	147	90	57	39
Physical medicine and rehabilitation	342	131	211	62
Plastic surgery	288	221	67	23
Psychiatry	3,441	2,732	709	21
Radiology	1,704	1,258	446	26
Therapeutic radiology	264	173	91	34
Thoracic surgery	273	178	95	35
Urology	1,016	808	208	20
Nonaffiliated hospitals	3,936	1,698	2,238	57
Anesthesiology	87	22	65	75
Child psychiatry	91	61	30	33
Colon and rectal surgery	9	3	6	67
Diagnostic radiology	50	40	10	20
Dermatology	15	15	0	—
Family practice	186	145	41	22
General practice	158	21	137	87
General surgery	735	226	509	69
Internal medicine	609	241	368	60
Neurological surgery	9	4	5	56
Neurology	13	3	10	77
Obstetrics and Gynecology	276	84	192	70
Ophthalmology	130	110	20	15
Orthopedic surgery	180	152	28	16
Otolaryngology	27	24	3	11
Pathology	231	47	184	80
Pathology-forensic	21	13	8	38

(Continued)

Appendix Table 6
(Continued)

Specialty	Total residents	U.S. and Canadian graduates	Foreign medical graduates	Foreign medical graduates as percent of total residents
Pathology-neuropathology	4	4	0	—
Pediatrics	188	70	118	63
Pediatric allergy	2	2	0	—
Physical medicine and rehabilitation	2	2	0	—
Plastic surgery	24	17	7	29
Psychiatry	690	274	416	60
Radiology	102	58	44	43
Therapeutic radiology	23	18	5	22
Thoracic surgery	12	5	7	58
Urology	62	37	25	40

Source: Graduate Medical Education, *Journal of the American Medical Association* 226:929, 1973.

Appendix Table 7
RESIDENTS IN HOSPITALS BY GEOGRAPHIC DIVISION AND STATE OF PRACTICE AND COUNTRY OF GRADUATION:
1972

Geographic division and State	Total residents	U.S. and Canadian graduates	Foreign medical graduates	Foreign medical graduates as percent of total residents
Total	44,858	30,418	14,440	32
New England	3,258	2,113	1,145	36
Connecticut	879	479	400	46
Maine	48	44	4	8
Massachusetts	1,944	1,320	624	32
New Hampshire	100	87	13	13
Rhode Island	178	82	96	54
Vermont	109	101	8	7
Middle Atlantic	11,882	6,047	5,835	49
New Jersey	922	201	721	78
New York	8,065	3,864	4,201	52
Pennsylvania	2,895	1,982	913	32
East North Central	7,985	4,522	3,463	43
Illinois	2,529	1,187	1,342	53
Indiana	476	401	75	16
Michigan	1,945	1,091	854	44
Ohio	2,352	1,327	1,025	44
Wisconsin	683	516	167	24
West North Central	3,381	2,594	787	23
Iowa	381	309	72	19
Kansas	344	271	73	21
Minnesota	1,212	1,014	198	16
Missouri	1,199	789	410	34
Nebraska	236	206	30	12
North Dakota	1	1	0	—
South Dakota	8	4	4	50
South Atlantic	6,184	4,600	1,584	25
Delaware	63	24	39	62
District of Columbia	1,226	907	319	26
Florida	1,114	821	293	26
Georgia	574	495	79	14
Maryland	1,173	686	487	42
North Carolina	757	685	72	10
South Carolina	285	245	40	14
Virginia	814	648	166	20
West Virginia	178	89	89	50
East South Central	1,680	1,408	272	16
Alabama	377	331	46	12
Kentucky	356	265	91	26
Mississippi	179	168	11	6
Tennessee	768	644	124	16
West South Central	3,015	2,500	515	17
Arkansas	182	176	6	3
Louisiana	694	579	115	17
Oklahoma	270	228	42	16
Texas	1,869	1,517	352	19

(Continued)

Appendix Table 7
(Continued)

Geographic division and State	Total residents	U.S. and Canadian graduates	Foreign medical graduates	Foreign medical graduates as percent of total residents
Mountain	1,338	1,199	139	10
Arizona	224	149	75	33
Colorado	685	651	34	5
Nevada	1	0	1	100
New Mexico	175	162	13	7
Utah	253	237	16	6
Pacific	5,739	5,290	449	8
Alaska	0	0	0	—
California	4,704	4,365	339	7
Hawaii	196	157	39	20
Oregon	312	290	22	7
Washington	527	478	49	9
Territories and Possessions	396	145	251	63
Canal Zone	31	17	14	45
Puerto Rico	365	128	237	65

Source: Graduate Medical Education, Journal of the American Medical Association, 226:931, 1973.

Appendix Table 8
 PERCENTAGE OF FOREIGN MEDICAL GRADUATES PASSING ECFMG EXAMINATION, BY
 COUNTRY OF GRADUATION:
 1970-72

Country of graduation	1970	1971	1972
Europe:			
Austria	34	28	41
Belgium	66	55	59
Bulgaria	28	13	29
Czechoslovakia	34	29	35
Denmark	90	85	84
East Germany	25	30	0
Finland	77	67	65
France	48	35	47
Germany	51	39	49
Greece	31	20	26
Hungary	28	23	32
Iceland	79	83	85
Ireland	54	57	74
Italy	34	30	34
Netherlands	71	59	71
Norway	90	97	100
Poland	24	21	30
Portugal	48	54	59
Romania	35	25	36
Spain	29	19	23
Sweden	83	76	89
Switzerland	75	73	82
Turkey	16	14	30
United Kingdom			
England and Wales	93	92	94
Northern Ireland	86	79	82
Scotland	87	82	89
USSR	15	6	10
Yugoslavia	25	18	24
Americas:			
Argentina	48	43	51
Bolivia	17	10	19
Brazil	44	29	43
Chile	67	52	61
Colombia	31	22	28
Costa Rica	71	65	70
Cuba	20	18	19
Dominican Republic	19	11	16
Ecuador	24	11	20
El Salvador	38	22	34
Guatemala	19	21	35
Haiti	21	12	28
Honduras	26	13	16
Jamaica	73	68	86
Mexico	27	20	28
Nicaragua	30	22	16
Panama	32	26	33
Paraguay	31	27	38
Peru	30	23	33
Uruguay	72	50	67
Venezuela	50	43	39

(Continued)

Appendix Table 8
(Continued)

Country of graduation	1970	1971	1972
Asia:			
Afghanistan	16	5	7
Bangladesh	— ¹	— ¹	30
Burma	24	15	37
Ceylon (Sri Lanka)	67	49	75
China (Mainland)	14	6	14
Hong Kong	86	92	89
India	40	28	41
Indonesia	34	26	40
Iran	26	13	26
Iraq	43	26	43
Israel	70	63	85
Japan	32	21	35
Lebanon	52	39	52
Malaysia	100	95	100
Pakistan	25	15	25
Philippines	12	12	23
Singapore	89	83	88
South Korea	56	53	56
North Vietnam	— ²	— ²	100
South Vietnam	18	13	32
Syria	33	17	35
Taiwan	63	47	42
Thailand	42	26	42
Africa:			
Egypt	38	22	34
Ethiopia	— ²	75	100
Ghana	— ²	73	65
Kenya	— ²	— ²	100
Nigeria	49	26	55
Rhodesia	85	77	100
South Africa	94	86	88
Sudan	75	0	33
Tanzania	0	33	0
Tunisia	0	— ²	100
Uganda	88	89	86
Oceania:			
Australia	99	96	97
New Zealand	97	91	92

¹ Country was part of Pakistan this year.² No candidates took examination.Source: *Medical Licensure Statistics for 1970, 1971, 1972*. Chicago: American Medical Association.

Appendix Table 2
FOREIGN MEDICAL GRADUATES EXAMINED FOR LICENSURE, BY STATE:
1964-72

State	1964 Examinations		1965 Examinations		1966 Examinations		1967 Examinations		1968 Examinations		1969 Examinations		1970 Examinations		1971 Examinations		1972 Examinations	
	Total	Percent pass	Total	Percent pass	Total	Percent pass	Total	Percent pass	Total	Percent pass	Total	Percent pass	Total	Percent pass	Total	Percent pass	Total	Percent pass
Total	3,235	68	3,011	68	3,900	63	4,187	62	4,955	63	4,913	64	6,251	63	10,380	65	9,113	64
Alabama	4	100	1	0	0	0	8	75	1	100	2	100	4	100	3	67	2	0
Alaska	9	89	2	100	0	0	-2	-	3	67	2	100	3	100	14	86	4	75
Arizona	19	79	12	83	5	80	9	89	23	70	38	79	52	65	55	67	40	55
Arkansas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11	73	14	71
California	126	74	63	79	125	86	192	85	317	77	358	53	205	44	594	60	661	49
Colorado	14	50	16	100	8	100	13	52	11	100	9	100	9	89	8	100	3	67
Connecticut	128	77	139	83	89	54	88	64	76	50	45	67	34	59	92	59	16	50
Delaware	4	50	10	60	16	38	20	85	12	83	14	64	29	59	44	89	96	63
District of Columbia	99	79	83	100	34	73	82	78	182	88	192	87	0	0	127	100	215	100
Florida	55	99	52	99	100	100	100	100	100	100	100	100	62	100	100	100	100	100
Georgia	21	100	27	89	16	100	23	96	27	70	26	96	32	94	76	100	155	100
Hawaii	15	53	12	92	14	79	20	85	13	92	16	88	12	100	33	48	30	67
Idaho	3	100	2	100	1	100	1	100	1	100	1	100	-2	-	1	0	2	100
Illinois	314	88	308	87	574	68	335	67	482	68	202	39	347	39	302	71	1,288	11
Indiana	34	100	23	100	124	67	182	71	193	59	292	48	206	35	261	31	178	31
Iowa	10	100	4	100	5	100	5	100	21	95	24	100	47	100	61	90	84	88
Kansas	11	100	12	100	9	78	23	87	7	88	12	58	44	89	52	100	96	86
Kentucky	28	96	10	70	53	81	38	84	20	75	95	71	67	70	22	100	63	100
Louisiana	-2	-	-2	-	9	100	22	86	24	88	32	88	45	87	52	58	54	59
Maine	81	52	72	63	101	57	101	60	131	47	97	55	218	60	296	51	90	100
Maryland	146	75	203	57	268	65	264	66	283	57	267	42	227	63	176	70	365	51
Massachusetts	71	45	9	100	74	64	138	71	137	77	5	100	193	60	81	74	214	63
Michigan	10	100	16	100	16	100	16	100	14	100	14	100	14	100	8	100	2	100
Minnesota	26	81	23	87	26	100	23	100	29	86	38	55	48	56	53	79	-3	-
Mississippi	5	100	6	100	9	33	20	95	14	100	19	89	11	91	16	94	9	67
Missouri	15	100	32	100	42	88	17	88	43	86	23	78	224	88	461	60	461	60
Montana	3	100	1	100	0	0	0	0	0	0	0	0	0	0	11	100	15	100
Nebraska	0	0	0	0	0	0	0	0	0	0	1	100	4	100	8	63	9	56
Nevada	2	100	-2	-	-2	-	-2	-	-2	-	-2	-	-2	-	4	50	8	50
New Hampshire	27	63	24	92	28	86	55	85	110	78	102	68	36	69	43	63	23	65
New Jersey	71	24	169	60	135	65	139	72	337	68	427	71	693	59	483	52	253	100
New Mexico	7	43	11	9	11	33	9	56	11	66	37	44	39	62	37	76	31	65
New York	1,037	57	822	48	873	49	831	41	709	36	615	44	712	39	1,693	52	-4	-
North Carolina	3	33	15	60	17	94	24	96	27	56	25	80	56	47	46	65	102	52
North Dakota	6	17	10	90	21	86	12	75	20	85	12	92	18	83	66	97	80	88
Ohio	71	93	68	85	51	78	53	57	65	26	41	29	51	8	722	65	472	53
Oklahoma	-2	-	-2	-	-2	-	2	50	23	100	1	100	5	80	10	50	17	100
Oregon	10	90	4	50	8	100	10	100	4	75	7	100	3	100	3	33	8	25
Pennsylvania	171	91	212	95	191	90	278	94	358	95	558	94	809	95	1,467	77	844	75
Rhode Island	12	100	32	78	19	88	31	65	41	61	24	75	21	76	14	79	21	86
South Carolina	1	100	1	100	1	100	1	100	1	100	1	100	1	100	1	100	1	100
South Dakota	9	100	1	100	5	80	2	100	15	87	1	100	11	91	11	73	20	95

(Continued)

Appendix Table 9 (Continued)

State	1964 Examinations		1965 Examinations		1966 Examinations		1967 Examinations		1968 Examinations		1969 Examinations		1970 Examinations		1971 Examinations		1972 Examinations	
	Total	Percent pass	Total	Percent pass	Total	Percent pass	Total	Percent pass	Total	Percent pass	Total	Percent pass	Total	Percent pass	Total	Percent pass	Total	Percent pass
Tennessee	0	0	0	0	0	0	1	100	2	100	0	0	8	100	48	100	53	100
Texas	117	89	117	94	93	87	55	91	100	78	82	78	169	82	155	86	159	63
Utah	35	89	2	2	2	2	2	2	2	2	2	2	6	6	21	21	21	21
Vermont	9	78	20	80	52	79	133	53	171	69	193	38	166	52	268	53	329	55
Virginia	166	84	188	83	456	50	459	39	292	42	200	48	214	45	458	51	826	55
Washington	25	88	39	92	42	90	44	95	61	89	94	85	139	72	149	76	71	92
West Virginia	17	88	11	73	17	88	17	76	22	41	62	40	114	42	79	68	96	47
Wisconsin	33	88	38	97	49	94	65	63	72	69	49	92	32	88	201	94	68	96
Wyoming	2	50	3	0	1	0	1	100	3	33	0	0	0	0	2	100	2	100
Puerto Rico	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Virgin Islands	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Canal Zone	57	84	50	100	7	43	—	—	121	92	76	92	92	93	124	97	121	96

¹ Excluding Canadians.² Not listed.³ Summary report only.⁴ Data not reported by county of graduation total examinations given were 2,270; percent passing was 39.Source: *Medical Licensure Statistics*. Chicago: American Medical Association, selected years.

Appendix Table 10
FOREIGN MEDICAL GRADUATES ¹ EXAMINED FOR LICENSURE, BY
COUNTRY OF GRADUATION:
1972

Region and country of graduation	Examination		Percent passed
	Total	Passed	
Grandtotal	9,113	5,817	64
Europe	1,394	916	66
Austria	16	12	75
Belgium	40	30	75
Bulgaria	4	2	50
Czechoslovakia	73	48	66
Denmark	2	2	100
Finland	3	2	67
France	33	20	61
Germany	105	76	72
Greece	88	50	57
Hungary	26	14	54
Iceland	4	4	100
Ireland	58	42	72
Italy	168	111	66
Latvia	1	0	—
Lithuania	3	1	33
Netherlands	13	10	77
Norway	1	0	—
Poland	81	48	59
Portugal	5	4	80
Rumania	51	29	57
Scotland	28	24	86
Spain	212	140	66
Sweden	9	8	89
Switzerland	72	52	72
Turkey	127	63	50
United Kingdom, England and Wales	89	74	83
USSR	7	3	43
Yugoslavia	75	47	63
Americas	1,472	865	59
Argentina	165	115	70
Bolivia	41	17	41
Brazil	31	23	74
Chile	37	28	76
Colombia	223	129	58
Costa Rica	3	3	100
Cuba	472	261	55
Dominican Republic	71	37	52
Ecuador	26	10	38
El Salvador	16	8	50
Guatemala	15	13	87
Haiti	34	20	59
Honduras	9	3	33
Mexico	193	107	55
Nicaragua	11	4	36
Paraguay	14	8	57
Peru	85	60	71
Surinam	1	1	100

(Continued)

Appendix Table 10
(Continued)

Region and country of graduation	Examination		Percent passed
	Total	Passed	
Uruguay	4	4	100
Venezuela	12	8	67
West Indies	9	6	67
Asia	5,955	3,824	64
Afghanistan	4	2	50
Bangladesh	3	3	100
Burma	59	36	61
Ceylon	31	30	97
China	69	32	46
Hong Kong	22	22	100
India	1,226	943	77
Indonesia	35	25	71
Iran	424	246	58
Iraq	49	43	88
Israel	32	23	72
Japan	69	44	64
Korea	716	465	65
Lebanon	46	38	83
Manchuria	2	0	—
North Vietnam	1	0	—
Pakistan	238	190	80
Philippines	2,149	1,119	52
Singapore	10	10	100
South Vietnam	5	2	40
Syria	43	32	74
Taiwan	427	308	72
Thailand	295	211	72
Africa	250	174	70
Algeria	1	0	—
Egypt	207	137	66
Nigeria	4	2	50
South Africa	35	32	91
Sudan	1	1	100
Uganda	2	2	100
Oceania	42	38	90
Australia	35	32	91
New Zealand	7	6	86

¹ Excluding Canadians.Source: *Medical Licensure Statistics for 1972*.
Chicago: American Medical Association, 1973.

Yale University *New Haven, Connecticut 06510*

SCHOOL OF MEDICINE

*Department of Epidemiology
and Public Health*

60 College Street

September 26, 1975

Mr. LeRoy Goldman
Office of Senator Edward M. Kennedy
Senate Office Building
Washington, D.C. 20036

Dear Mr. Goldman:

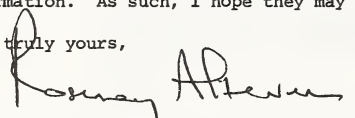
In connection with the coming health manpower hearings you may be interested in seeing the enclosed materials on the migration of physicians (FMGs) to the United States.

These pieces come up with findings with some rather different implications from statements on FMG immigration and "competence" which are in general circulation, namely:

- 1) The number of FMGs actually entering the U.S. each year has not increased substantially since 1965 (although the number changing their visa status has).
- 2) The number of FMGs entering from Asia has not increased substantially since 1968 (when the 1965 Immigration Law took effect).
- 3) Discussion of the "medical underground" is largely hypothetical: the evidence is not in.
- 4) There is little hard evidence on the competence of FMGs. Licensing cannot be used as a gauge of competence, since many FMGs are barred from licensing because of their "temporary" visa status. FMGs who become nationalized U.S. citizens appear to have no difficulty getting a license.

It may well be that there is a medical underground. FMGs may, on average, be less well prepared in medicine than Americans (although surely not after a three-year U.S. residency?). The purpose of these pieces is not to take an entrenched position, merely to question assumptions and to provide additional information. As such, I hope they may be of interest.

Very truly yours,


Rosemary A. Stevens, Ph.D.

RAS/my
Enclosures

How Many Immigrant Physicians?
A Critical Look at Migration Statistics

Rosemary Stevens
Louis Wolf Goodman
Stephen S. Mick
June G. Darge

W5-41

February 1975

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Rosemary Stevens, Ph.D. is Professor of Public Health and Institution for Social and Policy Studies, Yale University, Louis Wolf Goodman, Ph.D. is on the staff of the Social Science Research Council, Stephen S. Mick, Ph.D. is Research Associate in Public Health, and June Darge, M.A., is Associate in Research, Yale University.

SUMMARY

The number of physicians granted immigrant visas grew from 2,012 in 1965 to 7,119 in 1973. Over the same period the number of physicians entering the United States on temporary visas each year has continued to be substantial, with 4,114 and 5,144 foreign medical graduates, respectively, entering on temporary visas in 1965 and 1973. There has been a tendency to add these figures together to demonstrate a massive increase in the supply of FMGs since the Immigration Act of 1965. Data presented here show this practice to be erroneous. The majority of immigrant visas granted since 1971 have been to FMGs already in this country. The number of FMGs actually entering the United States in 1973 was 8,123, a figure somewhat below the output of graduates from U.S. medical schools.

Introduction

The number of foreign medical graduates (FMGs) entering the United States each year has been affected by the combined impact of independent and sometimes conflicting agencies. Job opportunities, particularly in-ternships and residencies, have been perhaps the single most persuasive factor in the migration of physicians to this country in the last two decades. In this respect, the "pull" of migration has been exerted by the demand of 1,400 employing hospitals for physicians.

But the freedom of the hospitals to offer positions to FMGs would not have been possible if visas for physicians had not been available. Immigrant visas have been made available to physicians on a relatively generous basis, compared with other groups, particularly over the last ten years: 7,119 immigrant visas were granted to physicians in fiscal year 1973. At the same time, residency review committees have been willing to approve residencies meeting their standards, without regard to the total number of interns and residents available each year. Thus, approved educational positions have been available for foreign-trained physicians entering the United States on exchange visitor visas: 4,614 in fiscal year 1973.

The two large visa programs that have developed for physicians theoretically reflect quite different functions. Physicians entering the United States as "permanent residents" on immigrant visas might be expected to remain in the United States for their careers. On the other hand, those seeking to come under the exchange visitor category were to be regarded as temporary migrants, who would presumably return to their native countries once U.S. training was completed.

It has, however, long been evident that this distinction is largely fictitious. Well before the Immigration Act of 1965 (Public Law 80-236), the exchange visitor program formed a haven for physicians who wished to enter the United States, but were unable to do so as immigrants because of quota limitations imposed, until then, by country of origin. By 1962 about 4,000 physicians were entering the United States as exchange visitors each year. In the decade 1962-1971, 47,000 doctors entered this country as exchange visitors, while 29,000 physicians were granted immigrant² visas.

As a result, an odd situation developed. While physicians from countries with relatively generous quotas in the years before 1965 were able to enter freely under immigrant visas, doctors from less favored nations could only enter on the "temporary" status afforded by the exchange visitor program, or other temporary visa programs. The United Kingdom is a notable example of the first category; countries such as the Philippines, India or Korea, of the second. In neither case did the visa status necessarily reflect the long-term career intentions of the individuals.

Graduate educational programs accounted for approximately 12,000³ FMGs in 1965, half of whom were from countries in Asia. While precise figures are not available, it is evident that the majority of those from Asia were in the United States on temporary visas. There was thus a large pool of physicians already in the United States in 1965, who might well seek to transfer from temporary to permanent resident status, i.e., from an exchange visitor to an immigrant visa.

The 1965 Legislation

The Immigration Act of 1965 replaced the old system of national quotas with one based on relative flexibility as far as national origin is concerned. Immigration visas are limited to a total of 290,000 a year for all occupations: 170,000 from the Eastern Hemisphere (with a further limit of 20,000 per country) and 120,000 from the West. At the same time, the skills of prospective immigrants, as they relate to apparent needs in the United States, were stressed.

These changes were to have two striking influences on physician visa status. First, since physicians are both highly skilled and in avowedly short supply in the United States, the total number of immigrant visas granted to physicians has risen. Immigrant visas to physicians fluctuated at around 2,000 a year in the years 1957 through 1965. From 1966, anticipating the new law, which took full effect in 1968, the number of physicians granted immigrant visas began to rise. More than 7,000 such visas were granted to physicians in 1972 and in 1973. (The figures are given in Table 1).

The second effect of the 1965 legislation was to change the national balance of immigrants in favor of countries previously restricted by the quota system. Notably, the number of immigrant visas granted to physicians from the Eastern Hemisphere rose dramatically. In 1965 less than 300 immigrant visas were issued to doctors from countries in Asia; in 1972⁴ and 1973, the annual number was well over 5,000.

Were immigration visas the only appropriate measure of physician migration to the United States, and if immigrants were always new arrivals, these trends would be extremely important for physician manpower policies

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in the United States.

Concentrating only on the immigrant visa program gives, however, a distorted picture of the migratory process. Not only were thousands of physicians already in the United States offered a possibility of a change of visa status under the new immigration arrangements, a substantial number of physicians have also continued to enter the United States on exchange visitor and other temporary visas: 5,033 in 1971, 4,270 in 1972, 5,144 in 1973 (Table 1). The effect of the new Immigration Act was thus both to encourage the transfer of individuals in the United States from temporary to immigrant visas -- the so-called "Adjustment of Status" -- and to strengthen the role of the exchange visitor visa as a channel of entry to the United States.

Such effects of the legislation were not, however, immediately evident, in part because of continuing changes in the visa system. During an interim period between 1965 and 1968, before the 1965 law went into effect, the old quotas of the 1952 law were maintained in modified form. If the quota of any country was undersubscribed, the unused visas were put into a pool from which they were made available to persons wishing to come from countries whose quotas were filled and which still had waiting lists. The results of this interim legislation were reflected in the published statistics in an immediate increase in the number of Asian physicians who were granted immigrant visas: 285 in 1965, 708 in 1966, 1,326 in 1967, 1,307 in 1968. These numbers were to rise again from 1969, as the law began to take full effect. (See Table 3).

The Immigration and Naturalization Service (INS), a division of the United States Department of Justice, did not, however, note in its regular-

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ly published statistics how many of the new "immigrants" were in fact physicians already in the United States under temporary visa arrangements. It had no particular interest in doing so. From the point of view of those administering the immigration laws the salient question is whether those admitted as immigrants are properly qualified under the legislation and its regulations, not where they happen to be living. The phrase "admitted as an immigrant" means "qualified to become a United States citizen" in the resulting INS statistics, and the date of such "admission" has no necessary correlation with the date the individual actually arrives in the United States. Those coming as exchange visitors are dealt with under different arrangements, and figures relating to their entry are⁵ tabulated separately.

How many immigrant visas were actually being granted to physicians in the United States became of increased importance with further changes in requirements in 1970 under Public Law 91-225. Up to this date, exchange visitors had been required to leave the United States for a period of two years in order, as it were, to "wipe the slate clean" before returning as an immigrant. To avoid the two-year rule, a formal application for a waiver had to be made to the Secretary of State, on the grounds that admission to the United States as an immigrant was in the public interest, or that the enforced absence of the individual would constitute an undue personal hardship. The 1970 law virtually abolished the two-year requirement. Since 1971, exchange visitors, with some exceptions, have been allowed to begin the process of visa "adjustment" at any time after arrival in the United States. Exchange visitors financed by their own government or by the United States government are exceptions to this

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privilege, as are those deemed necessary to the country of last permanent residence according to the application of a "skills list" developed by the State Department.⁶ However, the skills list provision applies only to those entering after April 1972.

The new legislation offered an immediate incentive to exchange visitors in the United States in 1970, or entering between 1970 and 1972, to take maximum advantage of "adjustment" procedures: i.e., to apply to become an immigrant. Again, however, the published statistics from INS and from the National Science Foundation made it impossible to tell how many physicians were in fact doing so.⁶ The separate publication of two sets of statistics, one for all immigrant visas granted in a given year, and one for temporary visitors, has confused the picture further. Immigrant visas granted to Asian-born physicians, for example, rose from 1,942 in 1970 to 5,558 in 1972, while the number of exchange visitors from Asia dropped somewhat in the same period, from 2,294 to 1,854 (Table 3). But what does this mean? At a glance, it appears that there was a massive increase in migration from Asian countries in the two-year period, an increase continued into 1973. No such conclusion can, however, be reached unless allowance is made for those in the category of "adjusting status."

The following tables, based largely on unpublished data from the National Science Foundation, attempt for the first time to measure net annual migration of physicians to the United States since 1965, by making allowance for immigrant visas granted to those already in the United States. The tables are designed to answer the following crucial questions: has there really been, as assumed, a large increase in migration since the 1965 Immigration Act, a massive inflow of Asian physicians, and a reduction

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in the supply from Western Europe? Have there been shifts in visa status among physicians entering the United States as nonimmigrants? What has been the actual contribution of FMGs as a proportion of entrants to the pool of physicians in the United States?

Data Limitations

Some limitations in the data should be noted. The INS is concerned with administering a series of visa programs, some being relatively more important than others. More information is available about immigrants than about exchange visitors and temporary workers; very little information for the host of non-working visitors, students and others who enter the United States each year.

The tables presented here do not include nonimmigrant physicians who come to the United States on visas other than those for exchange visitors, or those for temporary workers of distinguished merit, those whose services are not available in the United States, and industrial trainees (the "H" visas). Other physicians do come to the U.S. as students, visitors, parolees, refugees and in other capacities, and some may change⁷ to immigrant status, once here.

A more serious limitation occurs when regional and country comparisons are attempted. Immigration statistics are usually tabulated according to both the individual's country of birth (since the INS is interested in citizenship) and by his country of last permanent residence, but all "adjustment of status" figures are calculated only on the basis of country of birth. Exchange visitor and other temporary visas are tabulated according to country of last permanent residence or nationality (on the grounds that this is the country to which, presumably, the temporary worker will

return). While the two sets of data are not exactly comparable, cross-matched studies show that approximately 80 percent of all physicians enter the United States directly from permanent residence in their country of birth.⁸ The tables referring to country breakdowns (Tables 3, 4 and 5) are thus approximate, rather than exact. They are offered as the best assessments of physician migration from different regions possible from currently available statistics.

Migration to the United States 1965-73

Basic information on the migration patterns of physicians since 1965 is given in Table 1. The table shows that much of the increase in the number of immigrant visas granted since 1965 (col. 2) reflects adjustment of status by physicians already in the United States (col. 3). As might be expected, the process took place in two stages: first, in the transitional period, 1966-68, prior to the full implementation of the 1965 legislation; second, in 1971, when the 1970 legislation took effect. Transfers from temporary to immigrant status represented only 6 percent of all immigrant visas granted in 1965, 19 percent in 1966, 61 percent in 1972, and 58 percent in 1973 (col. 5). In this latter year, only 2,979 of the 7,119 new "immigrants" were actually new arrivals to the United States.

The number of exchange visitors (col. 6) has shown fluctuations year by year, but no major trend over the nine-year period. In 1971 the total number of immigrant visas granted in any one year overtook the number of temporary visas granted in the same period. Nevertheless, physicians entering the United States on temporary visas (col. 8) have consistently outnumbered those entering the United States as immigrants. In 1973, for example, only 37 percent of the 8,123 physicians who actually entered this country held immigrant visas; all others came as exchange visitors

or on other temporary visas. The comparable figure for 1965 was 32 percent.

Net migration under all visa categories shows no clear trend. The highest entry of physicians was in 1968, chiefly because of an unusually high number of exchange visitors in that year. All together, 66,757 foreign physicians actually entered the United States between 1965 and 1973, inclusive. Of these, 21,891 were immigrants and 44,866 arrived on temporary visas. Over the same period 14,976 physicians adjusted their visa from temporary to immigrant status. Some of these were in the United States in 1965; others entered during the period and are counted in the "non-immigrant" tabulations.

Table 2 gives the exact figures. As can be seen, well over one-fourth (N=4011) of the total of 14,976 "adjustments" since 1965 represent physicians who were in the United States at the time the Immigration Act of 1965 was enacted. Thereafter, the shift from temporary to permanent status has become quite rapid. One-third of all those who entered the United States on temporary visas between 1969 and 1971 had become immigrants by 1973. The potential speed of change of status should be remarked. Of the total of 4,270 non-immigrants who entered the United States in fiscal 1972, 1197 had become immigrants by the end of fiscal 1973; and 38 enterprising individuals entered in 1973 and managed to change their status within a one-year period.

The importance of taking adjustments into account in reviewing migration from particular world regions is illustrated in Table 3, which shows visa and migration trends from countries in Asia. Of the total of 5,414 immigrant visas granted in 1973, 65 percent were by adjustment of status. The net figures show almost a doubling in the annual migration of doctors between 1965 and 1968, from 2400 to 4200 respectively. The year

1968 proved, however, to be a peak year for migration. There has been no rapid increase in the annual entry of doctors from countries in Asia since 1968.

Interestingly, though, there appears to have been a shift in visa preference. Table 3 shows a dropping in the entry of exchange visitors (but not of other temporary visitors) from Asia after 1968, as the number of immigrant entries has risen.

These trends are underlined in examining one major source of physicians for the United States, India, in Table 4. This table shows relatively little use of the "adjustment" category until the 1970s (in part because of a delay in processing Indian applications), but then massive increases. The exchange visitor category reached its peak with respect to physicians in 1967. There has been little change in the total number of physicians entering the United States from India since 1967 -- i.e., since before the Immigration Act took full effect. Entry has remained at about 1000 new physicians per year. The large recent increase in "adjustments" suggests that most of these plan to remain.

Table 5 shows, in summary form, the net migration of physicians to the United States since 1965 from all major regions of the world. The number of doctors entering from Europe shows no clear trend. There has been no major decline in the number of doctors coming to the United States from Europe since 1965.

The annual number of entrants from North and Central America has showed little change over the period. The number of migrants from South America and Africa has, however, risen relatively rapidly.

Of the total of 67,000 physicians entering the United States between 1965 and 1973, inclusive, 23 percent came from Europe, 48 percent from

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Asia, 15 percent from North and Central America, 9 percent from South America, 3 percent from Africa, and 2 percent from other areas. As the number of entrants has risen, the proportion of entrants from different regions has changed somewhat, but by no means as much as has been generally assumed. For example, in 1965, 26 percent of the entrants came from Europe and 40 percent from Asia; whereas in 1973, 20 percent came from Europe and 46 percent from countries in Asia.

Need for Re-Thinking

The importance of FMGs to the physician manpower supply in the United States, and current debates over whether this supply is reasonable in relation to our needs, underline the urgent need for accurate statistics. Virtually all of the published papers and projections drawn from INS data to this date have, however, been erroneous. They have not allowed for shifts in visa status through "adjustment of status," since this information was not easily available. Thus there has often been double counting of those who have changed from one visa category to the next. Such individuals have been counted, first, on arrival in the United States on a temporary visa (under the rubric of "nonimmigrants"), and again when they change status (under the rubric of "immigrants").

The resulting exaggeration in the projections can be profound. We have been guilty of it ourselves: Table 6 provides an illustration. While the problem of double-counting has been widely recognized, estimates of the arrival flow of FMGs have usually been reached by adding together the number of new immigrants and exchange visitors in any one year, since these have been the statistics readily available. Column 2 shows the effect of this process from 1965 to 1973. If other temporary visas are also added (col. 3), the totals of column 4 are reached.

These figures suggest that 82,015 FMGs entered the United States in the nine-year period, rather than the 66,757 produced by the appropriately adjusted statistics. Moreover, the uncorrected data appear to indicate a rather rapid increase in the annual inflow of foreign physicians between 1965 and 1968, and again between 1971 and 1973. The uncorrected, average annual number of entries between 1965 and 1968 is 7,877, compared to an average of 10,101 between 1969 and 1973. These uncorrected figures also indicate that the addition of new FMGs outnumbered the number of graduates from U.S. schools (col. 7) in 1967 and 1968, and for each of the years 1970 through 1973. Thus they can be used as an apparently dramatic demonstration of the dependence of the U.S. health care system on foreign-trained physicians.

The corrected figures for new entrants to the United States are both much lower than has been accepted, and show different trends. The two sets of figures show a massive difference of 15,258 physicians over the period 1965-1973. Assuming arbitrarily that two-thirds of the physicians entering are likely to remain in the United States¹¹, this means that the use of uncorrected data overestimates the long-term contribution of FMGs by 10,000 physicians within a nine-year period.

Moreover, rather than staged increases in the entry of physicians before and after 1968, there appears to have been a relatively steady increase in annual migration over the period. An average of 7,291 physicians entered in the years 1965-68, compared with 7,519 between 1969 and 1973. Taking the two years 1965 and 1973, the revised figures show an increase in the annual entry of physicians of 35 percent: the uncorrected figures would give an increase of as much as 92 percent. The increase is still substantial, but far less than has been previously sug-

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gested. In 1973, there was more than a 50 percent discrepancy between the two sets of figures -- a direct reflection of increases in the "adjustments of status," which are accounted for in the revised figures.

A discrepancy to the tune of 15,258 physicians -- equivalent to well over one year's total current output of U.S. medical schools -- is a disturbing indication of the crude state of migration statistics. As Table 6 shows, foreign physicians have played a substantial role in the new supply of physicians for the United States. However, contrary to what has virtually become the folklore of the "FMG problem," the proportional contribution of FMGs has not increased substantially since 1965. If anything, it appears now to be falling. In only two years, 1967 and 1968, did foreign entrants to the United States exceed the number of U.S. graduates.

These facts cannot be too strongly stressed, in order to counteract what appears to be a general backlash against foreign physicians, particularly those from the Eastern Hemisphere. There is the possibility that the number of incoming FMGs will be sharply reduced in the next few years, using erroneous data in justification.

The primary reason for the discrepancies in available data is that no one agency has been responsible for the production of accurate physician manpower data. The need for such responsibility is self-evident, whether grasped by a governmental agency, such as HEW, or by a professional agency, such as the American Medical Association. This is the primary conclusion of this paper.

The second conclusion is that all assumptions relating to FMGs should be regarded as not proven, until incontrovertible evidence is available. The investigations reported here suggest a potential overcount of 15,000

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FMGs entering the U.S. since 1965, representing a long-term addition of perhaps 10,000 physicians. Such errors cannot be tolerated, if the United States is to develop a rational approach to the future supply of physicians, and if the future role of FMGs is to be planned to the optimal benefit of all participants.

FOOTNOTES

1. The Exchange Visitor or "J" visa program was developed by the United States Information and Educational Exchange Act of 1948 (Public Law 80-402), to encourage students to enter the United States for full-time study in approved programs. The original intent of the legislation was that the participant in the program would return to his homeland, bearing back both additional skills and feelings of friendship toward the United States. See Rosemary Stevens and Joan Vermeulen, Foreign Trained Physicians and American Medicine, DHEW Publication No. (NIH) 73-325, Washington, D.C., June 1972, pp. 49-64.

The Exchange Visitor program has attracted a disproportionate number of physicians since its inception. In fiscal year 1973, for example, a total of 46,468 individuals in all fields and professions entered the United States as exchange visitors. Of these 4,614 were physicians. United States Department of Justice, Immigration and Naturalization Service.

2. Stevens and Vermeulen, Table A2, p. 96.
3. A total of 12,394 interns and residents, of whom 6,057 were graduates of medical schools in Asia. "Medical Education" J. American Medical Association, 1966, Vol. 8, p. 918, Table 2.
4. The Immigration and Naturalization Service figures for physicians by region of the world go back to fiscal year 1957. In that year a total of 1,990 immigrant visas were granted, of which 155 were to immigrants entering the United States from Asia. Between fiscal 1957 and fiscal

1965, a total of 2,125 physicians from Asia were granted immigrant visas. Stevens and Vermeulen, Table A5, p. 99.

5. Basic figures are published in the Annual Reports of the Immigration and Naturalization Service, U.S. Department of Justice. The National Science Foundation also publishes a brief annual report on the Immigration of Scientists, Engineers, Physicians and Surgeons, together with more comprehensive information on an intermittent basis. All of the National Science Foundation's information, published and unpublished, is based on figures provided by the Immigration and Naturalization Service.
6. The skills list, although it was provided for in the 1970 legislation, did not appear until April 1972, presumably because of the lengthy consultations held between the State Department and the governments of the over 90 countries represented on the list. The list made mandatory the return home for two years after his training of any exchange visitor sponsored in the U.S. on government funds, whose skill was considered to be needed in his country because it was in short supply there. In the medical field each country could designate any one or all of the following skills it considered it needed: hospital administration, general practice of medicine, recognized medical specializations (some 20 are enumerated) or teaching in medical schools.

The skills list restrictions are, however, by no means universally applicable. The list only applies to exchange visitors, not to doctors entering on other visas. It does not apply to FMGs on exchange visitor visas

who come here on private, rather than government funds. Moreover, the foreign residency requirement can be waived if it would impose exceptional hardship to the exchange visitor's spouse or child of U.S. citizenship; if return to his country would subject the exchange visitor to persecution because of his race, religion, political opinion, nationality, or membership in a particular social group. Alternatively an interested U.S. government agency may submit a statement that the waiver of the foreign residency requirement would be "in the public interest" and that the visitor's country, transmitted through its foreign office, has no objection to waiving the requirement for that case.

7. Figures on the number of temporary visitors who adjust status are, unfortunately, not available. Our own studies suggest that the number of physicians who enter on temporary visas, other than as exchange visitors or as temporary workers, and then stay in the U.S., is relatively small. In a survey of interns and residents in 1974, we found less than 4 percent of a sample of 672 FMGs on visas which were not permanent resident, exchange visitor, temporary worker, or other H visas. Of the 637 who arrived between 1965 and 1973, 11 percent entered the U.S. as students, parolees, refugees or visitors. Details of this study will be reported shortly.
8. The remainder fell largely into two categories: those who have moved (or their country's boundaries have shifted) for political reasons; and those who enter the United States after a period of training in a third country, notably in Canada or Great Britain. Physicians of Pakistani birth who were granted U.S. immigrant visas in fiscal 1973 provide an example of both processes. Of the 292 visas granted to physicians born

in Pakistan, 195 were to those who had last lived in Pakistan, 49 to those who entered from India, 33 to physicians entering from Canada or the United Kingdom, and 15 from elsewhere. In fiscal 1973, the United Kingdom, and 15 from elsewhere. In fiscal 1973, 80.5 percent of the 7,119 immigrant visas granted were to physicians whose country of birth and country of last permanent residence were identical; for those born in Asia, the figure was 83.1 percent. For a detailed breakdown for fiscal 1972, see Thomas D. Dublin, *Foreign Physicians: Their Impact on U.S. Health Care*, Science, 2 August 1972, p. 410.

9. Further studies are needed, however, to determine how many of the physicians entering the United States from Europe on temporary visas are, in fact, European. That is, the number of transient physicians from countries like India would have to be determined and subtracted from annual European migration rates.
10. It should be noted that there were few graduates from African countries in 1965, and thus little possibility of extensive migration. Thus although the percentage increases are large, the absolute numbers are small (the same is true of "all other areas").

In Nigeria, for example, the University of Ibadan (founded in 1948) stood for many years as the sole medical school, although three more schools were founded in the 1960s. The only other west African medical schools were in Senegal (1949) and Zaire (1955). Sudan's medical school dates from 1924. But in east Africa, Makerere University (founded in 1924) provided the only medical school until the 1960s. A number of countries established medical schools in the 1960s in the wake of in-

dependence: Angola, Cameroon, Ivory Coast, Ethiopia, Ghana, Guinea, Kenya, Liberia, Mozambique, Tanzania, Rhodesia and Rwanda. How many of the graduates of these schools will migrate remains as yet to be seen. See World Health Organization, World Directory of Medical Schools, 1970, Geneva, 1973.

11. See James N. Haug and Rosemary Stevens, Foreign Medical Graduates in the U.S. in 1963 and 1971, Inquiry X March 1973, pp. 26-32; Rosemary A. Stevens, Louis Wolf Goodman, Stephen S. Mick, What Happens to Foreign-Trained Doctors Who Come to the United States? Inquiry XI, June 1974, pp. 112-124.

TABLE 1
Physicians and Surgeons: New Entries into the United States
All Countries

Year of Entry	Grand Total		Immigrants				Nonimmigrants								
	Total New Entries: Immigrants and Nonimmigrants	(1)	Immigrants	(2)	Adjustments of status from Nonimmigrants to Immigrants	(3)	Total New Entries: Immigrants	(4)	Adjustments of Percent of Immigrants	(5)	Exchange Visitors	(6)	Nonimmigrants: H-1, H-2, H-3	(7)	Total New Entries: Immigrants and Nonimmigrants
1965	6014	2012	112	1900	5.6	3904	210	4114							
1966	6628	2549	474	2075	18.6	4370	183	4553							
1967	8115	3325	841	2484	25.3	5264	367	5631							
1968	8405	3060	652	2408	21.3	5701	296	5997							
1969	6939	2756	576	2180	20.9	4460	299	4759							
1970	7630	3155	890	2265	28.2	5008	357	5365							
1971	7879	5748	2902	2846	50.5	4784	249	5033							
1972	7024	7143	4389	2754	61.4	3932	338	4270							
1973	8123	7119	4140	2979	58.2	4614	530	5144							
Total	66757	36867	14976	21891	40.6	42037	2829	44866							

TABLE 2

Adjustments of Status from Nonimmigrant to Immigrant by Year of Entry into U.S.

All Regions

Year of Entry	Year of Adjustment of Status							Total Adjustments of status	Total Non-immigrant Entries	Adjustments As Percent Total Non-immigrant Entries
	1966	1967	1968	1969	1970	1971	1972	1973		
Before 1965	407	659	341	327	412	593	251	111	3100	
1965	64	116	108	45	72	313	158	35	911	22.1
1966	3	66	152	73	84	412	322	55	1167	25.6
1967	-	-	51	72	103	513	551	112	1402	24.9
1968	-	-	1	59	132	410	681	236	1519	25.3
1969	-	-	-	-	86	375	684	391	1536	32.3
1970	-	-	-	-	1	236	923	660	1820	33.9
1971	-	-	-	-	-	50	757	1367	2174	43.2
1972	-	-	-	-	-	-	62	1135	1197	28.0
1973	-	-	-	-	-	-	-	38	38	0.8
Total	474	841	652	576	890	2902	4389	4140	14864	37.4

Physicians and Surgeons: New Entries into the United States

Year of Entry	Asia					
	Immigrants (1)			Nonimmigrants (2)		
Grand Total	Immigrants			Nonimmigrants		
	Total New Entries: Immigrants and Nonimmigrants	Immigrants	Adjustments of status from Nonimmigrants to Immigrants	Total New Entries: Immigrants	Exchange Visitors	H-1, H-2, H-3 Nonimmigrants
						Total New Entries: Nonimmigrants
1965	2376	285	80	205	2154	2171
1966	2980	708	295	413	2543	2567
1967	3838	1326	567	759	3067	3079
1968	4157	1307	436	871	3268	3286
1969	3331	1576	461	1115	2191	2216
1970	3571	1942	679	1263	2294	2308
1971	4106	4340	2529	1811	2217	2295
1972	3630	5558	3861	1697	1854	1933
1973	3754	5414	3523	1891	1756	1863
Total	31743	22456	12431	10025	21344	21718

(1) By region/country of birth.

(2) By country of last permanent residence.

Physicians and Surgeons: New Entries into the United States
India

Year of Entry	Immigrants (1)				Nonimmigrants (2)	
	Grand Total	Immigrants	Adjustments of status from Nonimmigrants to Immigrants	Total New Entries: Immigrants	Exchange Visitors	Nonimmigrants
	Total New Entries: Immigrants and Nonimmigrants	Immigrants	Adjustments of status from Nonimmigrants to Immigrants	Total New Entries: Immigrants	Exchange Visitors	Nonimmigrants
1965	n/a	20	n/a	n/a	352	4
1966	484	55	21	34	444	6
1967	1039	144	51	93	942	4
1968	996	134	52	82	907	7
1969	724	180	74	106	611	8
1970	982	357	124	233	745	4
1971	1169	1057	604	453	692	24
1972	1093	1802	1328	474	613	6
1973	974	1921	1400	521	450	3
Total	7461	5670	3654	1996	5756	66
						5822

(1) By region/country of birth.

(2) By country of last permanent residence.

TABLE 5
Physicians and Surgeons: New Entries of Immigrants and Nonimmigrants into the United States, 1965-73

Year of Entry	All Countries			Europe			Asia			China			India			Taiwan			Other Asia			North and Central America			South America			Africa			All Other Areas		
	\$	N	Change	\$	N	Change	\$	N	Change	\$	N	Change	\$	N	Change	\$	N	Change	\$	N	Change	\$	N	Change	\$	N	Change	\$	N	Change			
1965	6014		1567	---	2376		n/a	---	n/a	---	n/a	---	n/a	---	n/a	---	n/a	---	n/a	---	1282		528		528		261		261		261		
1966	6623	+10.2	1637	+4.5	2980	+24.4	17	---	484	---	97	---	---	---	2382	---	1206	-5.9	538	+1.9	538		538		267	+2.3	267		267		267		
1967		+22.4	2211	+35.0	3538	+28.8	32	+88.2	1039	+114.7	89	-9.8	2678	+12.4	1147	-4.9	562	+4.4	562		562		562		207		207		150		150		
1968	8405	+3.6	2302	-9.4	4157	+8.3	30	-6.2	996	-4.1	150	+68.5	2981	+11.3	1228	+7.1	706	+25.6	219	+5.8	219		219		93	-32.0	93		93		93		
1969	6939	-17.4	1722	-13.0	3331	-19.9	53	+76.7	725	-27.3	125	-16.7	2428	-16.7	959	-21.9	526	-25.5	273	+24.7	273		273		128	+37.6	128		128		128		
1970	7630	+10.0	1922	+11.6	3571	+7.2	48	-9.4	982	+35.4	96	-23.8	2445	-1.5	1031	+7.5	599	+13.9	365	+33.7	365		365		142	+10.9	142		142		142		
1971	7879	+3.3	1359	-29.3	4106	+15.0	109	+127.1	1169	+19.0	47	-51.0	2761	+13.7	1221	+18.4	821	+37.1	303	-17.0	303		303		69	-51.4	69		69		69		
1972	7024	-10.9	1367	+0.6	3630	-11.6	98	-10.1	1093	-6.3	87	-85.1	2352	-15.4	920	-24.7	737	-10.2	274	-9.6	274		274		96	+32.1	96		96		96		
1973	8123	+15.6	1593	+16.9	3754	+3.4	83	-15.3	974	-10.9	133	+52.9	2564	+9.0	1193	+29.7	946	+28.4	471	+71.9	471		471		161	+67.7	161		161		161		
	66757		15385		31743		470		7462		824		20611		10187		5963		2112						1357		1357		1357		1357		

(1) Included in All Other Areas.

(2) Includes Africa for 1965 and 1966.

(3) 1967-73 only.

Physicians and Surgeons: New Entries into the United States (a)

Year of Entry	New Entries (a) Immigrant and Nonimmigrant (1)	Stevens-Vermeulen Monograph Figures (b) (updated to '73) (2)	+H-Visas (3)	Total (4)	Difference between Col. (4) & Col. (1)		Total United States Graduates (7)
					Number	Percent	
					(5)	(6)	
1965	6014	6172	210	6382	368	6.1	7409
1966	6628	6922	183	7105	477	7.2	7574
1967	8115	8530	367	8897	782	9.6	7743
1968	8405	8829	296	9125	720	8.6	7973
1969	6939	7216	299	7515	576	8.3	8059
1970	7630	8166	357	8523	893	11.7	8367
1971	7879	10540	249	10789	2910	36.9	8974
1972	7024	11079	338	11417	4393	62.5	9551
1973	8123	11732	530	12262	4139	51.0	10391
Total	66757	79186	2829	82015	15258	22.9	76041

(a) New Entries include exchange visitors and immigrants who arrived in the United States in a given year. Not included are adjustments of status from nonimmigrant to immigrant, since they were persons already in the U.S.

(b) Rosemary Stevens and Joan Vermeulen, Foreign Trained Physicians and American Medicine, U.S. Department of Health, Education and Welfare, 1972, table A2.

Communication

The "Medical Underground": Some Thoughts and a Reply

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AND STEPHEN S. MICK, PH.D.†

IN THEIR ARTICLE, "Physician Manpower Data. The Case of the Missing Foreign Medical Graduates," *Medical Care* (Nov., 1971), Kleinman, Weiss, and Felsenthal match 28,000 names of foreign physicians on three computer tapes, each of which exists for quite different reasons and for different uses. The basic file was the listing of all doctors who immigrated to the United States between 1961 and 1971, compiled in the records of the United States Immigration and Naturalization Service (INS). The list includes all doctors who entered the United States on permanent resident visas in the ten-year period. The primary aim of the study was to match these names against two other basic files, records of the Educational Council for Foreign Medical Graduates (ECFMG) and the AMA's master file of physicians, in order to provide for the first time a complete listing of all physicians entering the United States (or at least those entering on immigrant visas), with ECFMG certification and AMA practice information interlinked.

We stress the basic purposes of the study in order to underline an aspect of the findings which may be misinterpreted by the casual reader. The investigators estimated that one-third of the names reported on the

INS file of physicians entering the United States between 1961 and 1971 were not in the AMA's master file of physicians for 1971. If one assumes that physicians entering as immigrants are likely to stay in the United States, and if one further assumes that the data are accurate (i.e., that the inability to crossmatch reflects a real situation and is not a function of errors of measurement or data processing), then it would appear that a third of all physician immigrants are swallowed up into American society without a trace of licensure and further professional affiliations. Given present immigration levels, about 3,000 of the 9,000 physicians who enter the United States each year would appear, as it were, at the airport or the dock, or change their status to that of immigrant once here, and then vanish into the hinterlands of medical America. The obvious question is "What are they all doing?"

Before such figures, however, are seized on as evidence of a massive influx of unqualified doctors into this country, it should be stressed that the numerical bases for such statements are tenuous, to say the least. A careful reading of the article makes this quite clear. Kleinman, Weiss, and Felsenthal are careful to note the limitations of the data. We should like here to highlight these limitations, to review briefly salient aspects of the methodology, to add some further interpretations to the data, and to provide additional data from our own studies in hope of further clarifying the issues.

It is essential, first, to understand what

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the estimation process in fact was; it was complicated so that a quick reading of the article may not make the procedures clear. Kleinman, Weiss, and Felsenthal began with a list of 27,710 names selected according to the designation "Physicians and Surgeons" from more than two million punch cards for all immigrants entering the United States. Name, year of birth, and sex were to be used as the primary means of identification of individuals for the purposes of crossmatching the INS list against the other two tapes.

Unfortunately, it proved virtually impossible to match the INS tape because the name format on its files was incompatible. As a result, an indirect matching was also attempted. The INS tape was matched against the ECFMG tape to produce ECFMG identification numbers, and the ECFMG numbers, which theoretically appear on the AMA's records, were used to identify individuals in the AMA tape. The snag here—and it is a major one—is that the AMA is only peripherally interested in ECFMG numbers, as the investigators discovered. ECFMG numbers were found to be recorded by the AMA for only 54 per cent of all FMCs on the tapes. Thus, this matching process could only be applied to half of the AMA tape; it is not clear how the two halves differed.

These two attempts to match the INS & AMA tapes produced 7,519 actual matches. Of the total of 27,710 names reported by the INS as immigrant physicians over a ten-year period, only 27 per cent could actually be located on AMA records. Practically speaking, the computer cross-matching attempt was a failure.

The investigators might well have stopped at this point, having provided overwhelming evidence of the need for compatible record-keeping systems. Instead, Kleinman, Weiss, and Felsenthal decided to estimate how many of the 73 per cent of immigrants not found on the AMA tape

were actually there, through the findings of a sample study. The remainder of the paper, as reported, is based on an individual search for a sample of 150 of the 20,191 unmatched INS names in the AMA's own records. (An additional 26 names were sought for special search by the ECFMG). The authors refer to this process as a "clerical" process, undertaken by the AMA staff. The guidelines for the search, including efforts, skills, and criteria used by the staff, are not stated. Nevertheless, 52 of the 150 names were successfully matched by the process, a success rate of 55 per cent.

The ultimate finding that an estimated 33 per cent of immigrants are not on the AMA file comes from a combination of the two activities. The investigators took the figure of 7,519 computer matches and added to it the proportion of those thought to be traceable from the findings of the sampling study: another 11,104, approximately 55 per cent of the remaining records. These two figures were then added to produce 18,623 potentially matchable records out of the total of 27,710 originally investigated. Ergo, 67 per cent of INS records were thought to be matchable against the AMA file, and 33 per cent were not.

That the estimation process was rough-and-ready is self-evident; the investigators do not pretend otherwise. Our reason for writing here is not to criticize the methodology but to question the interpretation of the results. As fellow investigators, we are not convinced by this paper that one third of all doctors who immigrated to the United States between 1961 and 1971, and who were still here in the later year, had somehow bypassed AMA records.

Undoubtedly, some doctors have slipped through the wires, particularly in the early 1960s: political refugees unable to acquire a U.S. license, who came to research jobs in universities or elsewhere, and physician wives accompanying their husbands. However, the figures of those not picked up by

AMA records are, we hold, probably of minor numerical importance, and would certainly fall far short of the potential number of 9,000 "underground" doctors which could be adduced from the Kleinman and Weiss statistics, as entering over the ten-year period.

Some specific comments should now be made on how the data can be interpreted, given their limitations.

1. The massive task of matching thousands of items of information on the three separate systems under investigation should not be underrated. No two of the three systems are comparable, and each is in some respects defective. The AMA tape lists physicians according to a medical education number which is a combination of country of medical education, school, year of graduation, and identification number. The ECFMG files list by a number assigned to each individual by that organization. The INS system provides yet a third independent numbering system, one, moreover, which has had poor data-processing capability until recently. A relatively large incompatibility rate was thus to be expected, because of inadequacies in each of the three files under investigation, and because of the lack of any common number for identification.

2. The investigators assume, for the purpose of argument, that virtually all of the physicians entering the United States on immigrant visas in the ten-year period were 1) alive and 2) located in the United States in 1971. We have no measure of FMG death rates, but would agree that these are unlikely to cause major incompatibilities, immigrant physicians being a relatively young population. The question of departure rates from the United States does, however, demand further investigation.

How many of the physicians who entered the United States as immigrants between 1961 and 1971 left again within the ten-year period? No data for this precise cohort

exist since the INS does not keep track of exit data, and since other records, notably the AMA's own files, are defective with respect to visa information. Some comments may, however, be made. Our own studies have noted that 26 per cent of FMG interns and residents whose names appeared on the 1963 AMA file did not appear on the file for 1971.¹ Since these were matched by the relatively precise AMA medical education number, and since it appears to be quite difficult for a name to be removed from the file without proof that the FMG has died or has emigrated, we deduce a definite overall attrition of any cohort of FMGs in the United States, at least over an eight-year period. It should be noted, however, that these observations include FMGs in all visa categories.

One can hypothesize that, on the whole, those holding immigrant visas in 1963 were much more likely to be bound in the United States in the seven-year or eight-year period.

Some inferences can be drawn from preliminary findings of a study of a national sample of FMG interns and residents which we are now in the process of analyzing. Of the 354 interns and residents in the study group who reported they held immigration visas in 1974, only 30 per cent said they would definitely stay in the United States; 19 per cent plan to leave and 45 per cent were undecided. (Comparable statistics for the 289 exchange visitors were 8 per cent, 55 per cent and 37 per cent.) While a majority of the FMGs will probably remain in the United States, irrespective of what they now expect to do, considerable out-migration is to be expected.

That this is so is a reflection of the operation of the visa system. Since 1968, under the amended Immigration and Naturalization Act, physicians from all countries, including the Asians who were so severely limited by the earlier legislation, have found it relatively easy to obtain a permanent resident

rather than an exchange visitor visa or, once they have arrived here as an exchange visitor to alter their status to permanent resident. There have been obvious advantages to individuals in so doing; notably, that the physician has an automatic choice of staying in the United States or leaving it. We would argue, tentatively, that the holding of an immigration visa reflects the relative ease of acquisition of that visa in the country of origin as much as the intention of the individual to remain permanently in the United States.

In summarizing this section of our argument, we conclude that a substantial part of the one-third lack of match between INS and AMA data in the Kleinman-Weiss-Felsenthal study is attributable to the departure of FMGs from the United States and FMG deaths. A follow-up study of a sample of the FMGs who immigrated in the early 1960s could elucidate this point.

3. What, then, is left? Undoubtedly, as both the investigators and we have noted, there is a pool of physicians in the United States who are not fully integrated into the U.S. system. We appear to differ, however, on the extent and implications of this pool in relation to the supply of physicians in the United States.

Our basic conclusion from Kleinman and Weiss's published studies is that it is virtually impossible to provide accurate estimates of this pool from attempts to crossmatch available data. We view the lack of a match of one-third of the names of immigrants against AMA records for 1971 as the expression of the three factors: first, and predominantly, of errors in the data, both in the basic files and in the matching process; second, of some FMG emigration in the ten-year period; and third, perhaps of least account, additions to the pool of "unlicensed" physicians.

Since the outstanding conclusion from the study, in our view, is that existing data sources cannot accurately be matched, we

join our colleagues at Harvard in urging detailed consideration of remedies for current defects in the information system. AMA records provide the only continuing system of physician data in the United States, and these provide the most likely base for further action—whether or not, as our colleagues suggest, this function is eventually assumed by the federal government. We should, however, perhaps note that the AMA file, for all its faults, appears to provide a relatively accurate listing of doctors in practice in the United States. Its failures lie in the incompleteness of information currently not regarded as of critical interest (*e.g.*, visa, ECFMG, and licensing data), and in its lack of a monitoring system for physicians entering low-profile or nonmedical jobs in the United States: notably, those not licensed and not in approved training positions, holding temporary licenses, and those not in active practice.

We do not feel that one can conclude from the evidence presented that there are many thousands of doctors in the United States whose names do not appear on AMA records; *i.e.*, that there is in fact a massive "underground," a point that has been made at some length elsewhere.² These differences in interpretation are vital to current debates. A number of recent reports on migration have suggested that FMGs are less competent than U.S. doctors, and there is a growing groundswell in professional and Congressional groups to stem the tide of doctor migration. Whether FMGs are in fact less competent than USMGs, a specter often raised about relative rates of licensure, is tackled by us elsewhere.³ Any data which apparently supports a policy of restriction of entry for FMGs will be enthusiastically embraced by planners, and may tend to be regarded far less critically by investigators in 1974 than it would have ten years or even five years ago. Such is a familiar human inclination.

The number of FMGs entering the

United States will probably be stemmed in the next few years, irrespective of what any of us investigators may suggest. It may well be that the march of policy making is going too fast to be stopped. Personally, we think some reductions are the right decision. However, we think it is dangerous to make such adjustments until the direction of overall United States health care policy is clarified. Furthermore, we make our plea that the arguments used regarding FMG migration should be thoughtful and objective, cognizant of holes in the data and the need for further facts, and that all efforts be made to avoid the potential hysteria and self-righteousness which could

so easily accompany any general acceptance that there is a vast army of unqualified foreigners entering the United States. Current data do not show this to be the case.

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SPECIAL ARTICLE

LICENSURE, COMPETENCE, AND MANPOWER DISTRIBUTION

A Follow-up Study of Foreign Medical Graduates

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Abstract Medical statistics report United States medical graduates licensed at higher rates than foreign medical graduates. This difference is often interpreted to show greater medical competence of United States graduates. This study questions this interpretation by analyzing 1971 licensure rates for both groups who had been interns and residents in 1963. We found that factors unrelated to competence—namely, visa-citizenship status and state of examination—are as-

sociated with holding a license. Moreover, quality of medical education is not an accurate predictor of licensure. It follows that the use of licensure rates as measures of medical competence distorts understanding of the quality of medical care in the United States. More probably, the difficulties in obtaining medical licensure experienced by foreign graduates result from the use of such graduates to relieve specific medical-manpower shortages. (*N Engl J Med* 292:137-141, 1975)

IN recent years large and increasing numbers of foreign medical graduates (FMG's) have come to the United States, ostensibly for training. A sizable proportion of these physicians have remained beyond their training period and have become permanent additions to the physician-manpower pool in this country.^{1,3} Researchers have expressed interest in the unique role of the FMG in the American health-care system. Issues have been raised about type of practice,^{4,7} choice of specialty,^{1,4-11} geographic mobility,^{1,6,8,12} length of stay in the United States,^{2,4,5,8,12} and above all competence.^{1,5,6,9-11,13,14} Of all these questions competence is perhaps the most important, and at the same time the most difficult to evaluate. Whether FMG's, as a group, are as competent as (or more or less competent than) their United States peers is an issue raised whenever the FMG's role in this country is being discussed. It is the purpose of this paper to examine the validity of the assumption that licensure is, in the main, a measure of competence and to identify a set of factors that are associated with the ability to obtain a license.

A license to practice medicine in one of the 54 states and territories of the United States represents public recognition of a minimum level of safety and skills. But the license cannot be used as a proxy for competence without consideration of two fundamental characteristics of the licensing system. It is, first of all, a federated system, administered by independent jurisdictions. This fact indicates important variations in access to examinations by state, differences in the interpretation of test results, and (up to very recently) different tests in different states.¹⁵ None of these variations are directly related to competence per se. Secondly, the state examining boards, in interpreting their role as professional as well as public agencies, may impose clear-cut prerequisites to licensure that are techni-

cal rather than qualitative in effect. Examples are requirements that FMG's be United States citizens (a requirement of four boards in 1973), or have posted Declarations of Intent to become citizens (28 boards), or that they hold an immigrant visa (seven boards). These limitations are employed by state examining boards, not only to help assure physician competence, but also to deal with physician-manpower problems that may occur within their jurisdictions.¹⁶

This paper pays special attention to a comparison of the licensure of United States medical-school graduates, FMG's, and United States-born, foreign-trained physicians to address two main issues: whether differences in licensure rates are simply a function of being foreign-trained or United States-trained, or whether other variables such as visa-citizenship status and state of licensing examination must be taken into consideration, and how adequate a predictor of obtaining a license to practice medicine in the United States is the quality of the graduate's medical education.

METHOD

The population used in this study consisted of all interns and residents who were training in the United States in 1963 and were identified as being in the United States in 1971. American Medical Association records identified 37,287 interns and residents in the United States in 1963. The 991 graduates of Canadian medical schools were excluded from this study.* Of the remaining 36,296 physicians, 3077 were not listed in the AMA files in 1971 and were presumed to have died or left the country; virtually all of them (2611) were FMG's. The study group thus consisted of 33,219 physicians. Of these, 26,769 were graduates of United States schools, 5632 were graduates of foreign schools who were born outside the United States (FMG's); and 818 were American-born foreign graduates. By selection of a cohort of physicians eight years after the base year, it was possible to analyze the career patterns of a group of physicians no longer in training and to delineate factors that appeared to be correlated with licensure.

*Although technically foreign medical graduates, Canadian graduates have tended to be grouped with U.S. graduates in AMA studies because procedures for accrediting the schools are similar for both countries. Since we were interested in differences between U.S. graduates and graduates of schools outside the United States and Canada, our decision was to exclude Canadian graduates from the study.

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Some limitations in the data should be mentioned. Information on the licensing of individual physicians is, in theory, passed routinely from the state boards to the American Medical Association for incorporation into the master file, which is updated on a continuing basis. But doubts have been raised about the completeness of information in the AMA master file.^{14,17}

Citizenship and visa information* requires careful interpretation, since the AMA does not collect such information on a systematic basis. There is no routine system for updating information where, for example, an exchange visitor transfers to immigrant status, or an immigrant becomes a naturalized United States citizen. The data on visa status should thus be interpreted with the understanding that some of the information may be outdated, and that the data reflect the visa status of different graduates measured at different points in time.

RESULTS

There is a wide difference in the licensure rate for graduates of United States medical schools and graduates of foreign medical schools at the end of the eight-year follow-up period. Of the 5632 FMG's in the study group who were in the United States in 1971, only 66 per cent were licensed. In contrast, 93 per cent of the 26,769 United States graduates held United States licenses, as did 91 per cent of the 818 United States graduates of foreign schools.

Table 1. Licensure Rates of Foreign Medical Graduates (FMG's) and Graduates of U.S. Medical Schools (USMG's) by a Given Year.

Yr	% FMG LICENSED RATE	% USMG LICENSED RATE
By 1963	9	44
By 1964	15	56
By 1965	21	63
By 1966	28	69
By 1967	37	74
By 1968	41	80
By 1969	52	85
By 1970	61	89
By 1971	66	93
Total number in U.S. in 1971	5,632	26,769

FMG's were licensed not only at a lower rate than United States graduates but also at a slower rate (Table 1). Of the 66 per cent of FMG's licensed by 1971, over a third had been licensed within the preceding three years. The FMG licensure rate increases with time. If a follow-up period of 12 or 15 years had been selected, there might have been a much smaller difference in the licensing rates of these two groups. However, this observation should not obscure the fact that many FMG's are unlicensed physicians for a longer proportion of their careers than their American-trained counterparts.

*The visa categories referred to in this paper represent the visa status as reported on the file at year-end 1971: the *exchange visitor visa* — a visa given to an alien who is in the United States for a limited time as a student, trainee, or teacher; the *permanent resident (immigrant) visa* — a visa given to an alien that permits him to remain in the United States indefinitely; *other* — all other visa categories (students, temporary workers, etc.), constituting 1.0 per cent of the visas held by the study group. Since 1963, a number of changes in the immigration laws have generally made it easier for alien doctors to become permanent residents. However, the older restrictions still affected our study group, since they had already entered the United States by 1963. For example, if an exchange visitor in our group wished to change to immigrant status, he had to leave the United States for two years.

Correlates of Licensure Rates

State of licensure. There is considerable variation among states in licensure rates. Looking at states that had at least 90 FMG's, one finds that 91 per cent of the FMG's in Florida in 1971 held full and unrestricted licenses (Table 2) whereas only 29 per cent in New Jersey held New Jersey licenses. The data indicate that although the state licensure patterns for FMG's vary widely, the proportion of licensed United States graduates fluctuates little. In 14 of the states cited in Table 2, over 90 per cent of the United States graduates were licensed. It appears that the variation in licensure rate of FMG's is not attributable to state attitudes toward licensing as a whole, but is a factor peculiar to FMG's or to the way they are treated in those states. Differential migration of FMG's and United States graduates does not appear to account for variation in licensing. The state of location of FMG's in 1963 and in 1971 is the same 51 per cent of the time, and the comparable figure for United States graduates is 49 per cent.

To analyze the differences more fully, licensure rates in the 15 states with 90 or more FMG's were examined for Filipino medical graduates, whose country sent the greatest number of graduates to the United States. The same overall pattern was obtained. The greatest proportion was licensed in Missouri, 92 per cent, and the smallest proportion in New Jersey, 6 per cent (Table 2).

The number of graduates from the Philippines was large enough to control for medical school. The results are given in the last column of Table 2 for medical graduates of the University of Santo Tomas, the school with the largest number of graduates in the study population. Again, wide differences remained: only 8 per cent of the Santo Tomas graduates were licensed in New Jersey as compared with 100 per cent in Missouri. These are graduates of the same medical school in graduate education in

Table 2. For States with 90 or More FMG's, 1971 Licensure Rates for USMG's and FMG's, for All Filipino Medical Graduates and for Medical Graduates of the University of Santo Tomas, Manila.

STATES IN DESCENDING ORDER OF FMG LICENSE	USMG		FMG		FILIPINO MEDICAL GRADUATES		UNIVERSITY OF SANTO TOMAS GRADUATES	
	% LI- CENSED	TOTAL IN STATE	% LI- CENSED	TOTAL IN STATE	% LI- CENSED	TOTAL IN STATE	% LI- CENSED	TOTAL IN STATE
Florida	97	976	91	232	61	18	78	9
Missouri	97	460	89	91	92	25	100	15
Pennsylvania	96	1,380	84	261	79	66	80	45
Texas	93	1,316	83	176	64	11	63	8
Illinois	96	983	81	417	60	87	55	55
California	97	4,265	80	235	73	62	76	41
Virginia	90	563	77	117	52	23	58	12
Ohio	96	883	74	363	60	102	65	62
Maryland	79	721	74	300	62	97	62	53
New York	97	2,377	68	1,355	33	351	32	219
Massachusetts	93	1,142	55	161	28	25	26	19
Wisconsin	96	539	53	93	54	46	59	32
Michigan	95	831	39	313	26	80	24	41
West Virginia	96	89	33	101	27	55	31	29
New Jersey	93	755	29	335	6	112	8	73
Other	89	9,489	60	1,082	56	235	55	142
Totals	93	26,769	66	5,632	46	1,395	47	855

Table 3. 1971 Licensure Rates for USMG's, Foreign-Born Graduates of U.S. Medical Schools (FUSMG's), U.S.-Born Graduates of Foreign Medical Schools (USFMG's), and FMG's.

GROUP	% LICENSED	TOTAL CANS.
USMG's	93	25,718
FUSMG's:		
Naturalized US citizens	91	681
Permanent residents	92	561
Exchange visitors	89	98
USFMG's	64	22
FMG's	91	818
Naturalized US citizens	66	5,632
Permanent residents	89	1,090
Exchange visitors	76	1,728
	43	1,679

the United States at the same period. It is unlikely that differences in medical training alone could account for such large variations. It must be concluded that the variation in the licensure of FMG's among the states is not solely a statement about the competence of the physician taking the licensing examination. Other factors contribute to these differences. One of them is state of licensure.

Visa-citizenship status. For all FMG's, there is a direct relation between visa status and licensure: the nearer to United States citizenship, the greater the chance of holding a license. The FMG's in our sample who were native-born citizens of the United States had a licensure rate almost as great as that of United States graduates; FMG's who were naturalized citizens did almost as well, and permanent residents were next in line, with exchange visitors falling at the end (Table 3). As with variations by state, the possibility exists that these variations in licensing rates reflect differences in cultural background, language or medical training. However, when the data are again controlled for medical school, the University of Santo Tomas, wide differences in the licensure rates for the different United States visa or citizenship categories among FMG's remain. All United States-born FMG's from Santo Tomas in the United States were licensed in 1971, but during the same period, only a third of the FMG's from this school on exchange visas secured licenses.

The next step is to examine state licensing patterns controlling for visa-citizenship status (Table 4). For FMG's on permanent-resident and exchange-visitor visas the pattern of marked variation by state is repeated. Missouri and Pennsylvania had licensure rates that were higher than those in New Jersey and West Virginia. This pattern does not repeat for naturalized citizens. As Table 4 shows, all but two of the 15 states had licensed over 80 per cent of the naturalized citizens. The mean for the remaining states was also over 80 per cent. The findings of this section indicate a second factor associated with medical licensure: visa-citizenship status.

Quality of medical education. A subgroup of the study population highlights the importance of visa and citizenship status in securing a license. Foreign-born graduates of United States medical schools receive training identical to that of native-born graduates of the same schools. Nonetheless, if they hold exchange-visitor visas, their chances of being licensed are more like those of FMG's (64

per cent and 43 per cent respectively) (Table 3). In contrast, those foreign-born graduates of United States schools who have become naturalized citizens have licensure rates virtually identical to those of native-born graduates of United States and foreign schools (92 per cent, 93 per cent, and 91 per cent respectively) (Table 3). In short, the mere fact of graduating from a United States medical school does not guarantee medical licensure in the United States.

These findings also cast doubt on the hypothesis that FMG's are prevented from obtaining a license not by state licensing practices or visa-status barriers, but because of lack of familiarity with United States customs and language. All the foreign-born graduates of United States schools had been in the United States at least 12 years before these data were collected, and they had succeeded in obtaining an M.D. from a United States medical school. Yet those on exchange-visitor visas had markedly lower licensure rates than foreign-born graduates of United States schools of any other visa-citizenship status. We hypothesize that this differential is less a result of cultural-language problems or of plans to return home than of their inability to change from temporary visas (exchange visitor) to a more permanent status. As indicated before, exchange-visitor status is a near fatal block to obtaining a United States medical license in many states.

DISCUSSION

This eight-year follow-up study of medical-school graduates has examined some of the variables that are associated with licensure of physicians. The data show wide differences in the licensure rates between graduates of foreign medical schools (FMG's) and graduates of medical schools in the United States. Over a third of the former in the study were unlicensed as compared to just 7 per cent of the latter. Since this study included only physicians who

Table 4. 1971 Licensure Rate for Major Visa-Citizenship Status Categories in States with at Least 90 FMG's.

STATES IN DESCENDING ORDER OF % FMG'S LICENSED	USFMG		NATURALIZED CITIZEN		PERMANENT RESIDENT		EXCHANGE VISITOR	
	% LI- CENSED	TOTAL IN STATE	% LI- CENSED	TOTAL IN STATE	% LI- CENSED	TOTAL IN STATE	% LI- CENSED	TOTAL IN STATE
Florida	85	27	94	81	95	92	63	24
Missouri	100	2	94	17	92	25	86	29
Pennsylvania	97	31	94	36	92	79	73	84
Texas	95	19	84	31	91	92	65	34
Illinois	88	17	90	104	85	122	67	104
California	92	62	87	83	83	60	67	49
Virginia	86	7	100	18	81	43	52	31
Ohio	100	11	95	85	85	85	51	106
Maryland	92	13	82	28	93	93	57	126
New York	98	312	91	220	86	413	41	451
Massachusetts	71	14	84	32	67	46	36	47
Wisconsin	100	1	69	13	67	30	41	29
Michigan	83	12	98	47	51	107	7	102
West Virginia	50	4	62	13	50	12	23	52
New Jersey	94	78	85	80	22	77	1	109
Other	80	208	82	202	63	352	41	302
Totals	91	818	89	1,090	76	1,728	43	1,679

were no longer in training and who had completed their internship at least seven years earlier, the proportion of unlicensed FMG's is high. Other researchers have reported a high failure rate of FMG's on licensing examinations.^{8,9,10} However, in all these studies, failure rates have been reported for an FMG population that includes a large proportion of interns and residents, not a group of physicians uniformly advanced in their careers as is the present sample.

The wide difference in the licensure rate between graduates of United States and foreign medical schools is an important finding given the current climate of concern that FMG's may on the average be less competent than United States graduates. There is a tendency to use licensing data to support this argument.^{8,9,10} It is true that FMG's are less successful than graduates of United States schools in obtaining medical licensure¹¹; however, comparisons in this area are difficult since most graduates of United States schools do not take the state licensing examination but receive their licenses by endorsement of National Board Examinations. In contrast, the FMG must take the local state examination or the Federation Licensing Examination, neither of which is identical to the National Board Examination.¹² Since FMG's are precluded from the National Board and since United States graduates rarely take the Federation Licensing Examination, it has been difficult to make well controlled comparisons. Although comparisons between graduates of United States and foreign medical schools are often made in the states that use the Federation Licensing Examination,^{8,18} matched studies have not yet been done from raw scores. Such studies are especially needed since state boards differentially weigh and "factor" the raw scores before determining whether a license will be granted.

Although this study, too, must rely on less than ideal statistics, our findings challenge the notion that licensure and competence are automatically related. The findings in this study suggest that variables unrelated to competence—namely, state and visa-citizenship status—are important correlates of medical licensure in the United States. Although previous research has suggested that visa status is an important element in the licensing of FMG's,^{8,18} this study demonstrates the quantitative effect. The pattern is clear: the closer the FMG is to United States citizenship, the greater the probability of his being licensed; in certain states (e.g., Florida and Missouri) licensing rates for graduates of foreign and United States schools are similar, but in other states (e.g., New Jersey and West Virginia) licensing rates for graduates of United States schools are far higher than those for FMG's.

It is arguable, of course, that causality runs not from visa status to licensure, but that some FMG's, particularly those on exchange-visitor visas, do not become licensed because they have no intention of staying in the United States, and therefore have no need of a United States license. We reject this hypothesis for two reasons. The first is that, with some exceptions, it is unlikely that an FMG would continue to stay in the United States on an exchange-visitor visa seven years after having been enrolled in a United States program of graduate medical education

unless he expected to remain in this country. Secondly, since a license gives flexibility in career choice, FMG's uncertain of their career plans are likely to try for a license while still close to their training period. In fact, in a survey study of 1973-74 FMG interns and residents, we found that the majority of FMG's who do plan to return home also hope to obtain a United States license.

More probably, some of the differences in licensure rates might be explained by differential bureaucratic treatment of graduates of foreign and United States schools in the medical-licensing process. State licensing boards are not only arbiters of competence, but also de facto manpower-planning agencies. The introduction of the limited license, now in use in 43 states, points up the manpower-planning function of licensure. In 1972, four state licensing boards offered limited licenses to physicians who were willing to work in areas experiencing a severe shortage of physicians; the physician was not licensed to practice outside these areas. Ten other state licensing boards offered limited licenses that were even more restrictive; in these states the physician was licensed to practice in a particular institution (usually a state, municipal or county hospital) with a manpower shortage.¹⁹

The low rate of licensure of FMG's in New Jersey is suggestive of a way in which licensure is related to physician manpower needs. In 1971-72 New Jersey had a 32 per cent vacancy rate in internships and a 20 per cent vacancy rate in residency positions throughout the state, as compared to 12 per cent and 10 per cent rates respectively for the entire United States.¹⁹ A bill introduced in the 1972 legislature suggested that FMG's who had not passed the examination of the Educational Council for Foreign Medical Graduates* be permitted to work in New Jersey's hospitals.²⁰ The bill was defeated. The strategy of attracting large numbers of FMG's, licensing relatively few of them, and requiring the unlicensed FMG's to work in certain institutions could allow certain states to ease the critical shortage of physicians needed in hospitals. One statistical artifact that would result from such a strategy would be a high proportion of unlicensed FMG's.

An alternative explanation posits that FMG's are not licensed *because* they work in hospitals. This argument would add that the high rate of FMG's in hospital-based practice results from a combination of difficulties in obtaining initial capital, racial prejudice, and FMG lack of enthusiasm for private practice. Since hospital positions often do not require licenses, FMG's do not seek them, and their collective licensure rates suffer. This argument, however, does not explain the differential rate of private practice among FMG visa-citizenship categories. For our study group, 37 per cent of FMG's on exchange-visitor visas were in private practice as compared with 52 per cent of the permanent residents and 62 per cent of the naturalized citizens.

*The Educational Council for Foreign Medical Graduates examination is a standard examination, given by the Council to screen graduates of foreign medical schools who wish to come to the United States for graduate medical education or other kinds of medical practice. It has been given semiannually since 1958, is a 6.5-hour examination, and contains a medical-knowledge section and an English-language section.

Although our data are in many respects inconclusive, they suggest that variation in licensure practices allows states — and thus the United States as a whole — to meet specific needs in the health-care system. FMG's are available, are reasonably flexible in terms of specialty and types of posts that they will accept, and in many cases are in a vulnerable position because of their visa situations. In short, FMG's constitute a readily usable reservoir of physician manpower that can be tapped when and where needed, through the operation of the licensure system. The availability of such a reservoir allows states to respond to perceived shortages in a flexible fashion, but it also weakens the will to carry out effective long-term medical manpower planning in the United States. We leave open for discussion whether licensing procedures should continue to vary by state, and whether citizenship and visa requirements are appropriate rationing devices.

We are indebted to the Center for Health Services Research and Development of the American Medical Association for providing the data on which this work is based.

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The Foreign Medical Graduate

A third of the physicians now beginning their career in the U.S. received their education abroad. This substantial proportion reflects underlying flaws in the American system of delivering health care

by Stephen S. Mick

As recently as 1950 most of the physicians beginning their career in the U.S., as measured by the number of internships and residencies filled, were graduates of medical schools in the U.S. and Canada. The ratio was almost 10:1, that is, 10 graduates of North American medical schools for each graduate of a foreign medical school. Today the ratio is 2:1. In five of the seven years through 1973 the number of foreign medical graduates obtaining American visas was larger than the number of graduates of all American medical schools. By the end of 1973 more than a fifth of the physicians practicing medicine in the U.S. and Canada (77,660 out of 366,379) had been to medical schools elsewhere.

Clearly the graduates of foreign medical schools have had a strong and increasing numerical impact on the practice of medicine in the U.S. Have they also had a qualitative effect? The answer to that question is less clear; indeed, the question is the subject of considerable debate among people who pay close attention to the system of health care in the U.S.

Although the U.S. is by no means the only country receiving foreign physicians, it outdoes all other countries in the number of physicians and in the number of originating countries involved. Before 1965 most of the foreign medical graduates arriving in the U.S. came from other countries of the Western Hemisphere

and from Europe. Since 1965 Asian sources have predominated, chiefly as a result of changes in the immigration law under the Immigration Act of 1965.

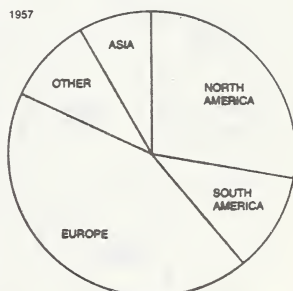
Another aspect of the migration is that in general the countries contributing the largest numbers of physicians to the U.S. have the fewest physicians available for their own population. (The major exceptions are Canada and the United Kingdom.) In other words, the underdeveloped nations are educating thousands of physicians who ultimately end up practicing in what is perhaps the most developed nation of all.

The migration raises several other questions that are deceptively simple. How is it that a nation with the immense medical resources of the U.S., including the high ratio of one physician for every 650 people, is also the largest importer of foreign physicians? What is the explanation for the fact that a fifth of the nation's physicians, a third of the interns and residents, a fourth of the psychiatrists, a third of the full-time hospital physicians and almost half of the physicians newly licensed in 1973 are the product of foreign medical schools? How can this large and increasing inflow be occurring at a time when American medical schools are turning away more applicants than ever before, even though both the number of schools and their enrollment have increased in recent years?

The search for answers to these questions begins with an examination of

changes in migration patterns in the 20th century and with a look at a series of postwar events affecting both immigration policy and the staffing of hospitals. At the outset one should view the flow of foreign medical graduates in the larger context of professional migration over the past 70 years. Between 1901 and 1910 only 1 percent of the immigrants to the U.S. were classified as "professional, technical and kindred workers," a category that includes physicians. By the decade from 1961 through 1970 the category constituted 10.2 percent of the total.

A factor contributing to the increasing



REGIONAL DISTRIBUTION of countries contributing foreign medical graduates to

migration of physicians is the unceasing demand by hospitals for house staff, meaning interns and residents [see top illustration on page 19]. Although the supply of physicians from both American and foreign medical schools has risen steadily, it has yet to fill all the positions the hospitals offer. For years the number of unfilled positions has ranged between 4,000 and 9,000 per year.

In part this unfilled demand and the rising flow of foreign medical graduates to help meet it reflect various efforts by the U.S. since World War II to encourage educational exchange programs. For example, the exchange-visitor program enables any foreign student who is in the U.S. under an approved program to remain until his studies are completed. Although it was explicitly stated that such programs were not intended to help hospitals meet their needs for staff, the spirit of the law has been ignored. By 1961 nearly half of the some 2,600 exchange-visitor programs then in effect were sponsored by hospitals.

Because of concern in certain countries about the loss of medical graduates the U.S. Department of State instituted in 1972 a "skills list," which was designed to enable interested countries to specify what occupations they thought were short of people. Anyone in such an occupation who has come to the U.S. with financial aid from his government or on an exchange-visitor visa must return to his home country for two years after he finishes his American studies. For reasons that are not altogether clear, many nations have taken little or no advantage of this option to curb the outflow of physicians and other health-care workers.

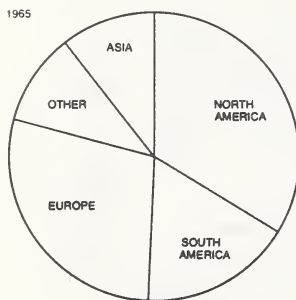
Nonetheless, the number of foreign medical graduates coming to the U.S. on exchange-visitor visas has declined in recent years. During the same period, however, the number entering on standard immigrant visas has increased. The reason is the Immigration Act of 1965, which abolished the long-standing system of quotas based on national origin. It sets a ceiling of 120,000 immigrants per year from countries of the Western Hemisphere, with no country quotas and acceptance on a first-come, first-served basis. The ceiling for immigrants from outside the Western Hemisphere is 170,000, with no more than 20,000 from one country. Physicians and surgeons receive preference over certain other kinds of immigrants, but in most cases the country quotas are so generous that physicians can immigrate without invoking the preference. The effect of the law has been twofold: more physicians and many more Asian physicians are immigrating.

So far I have described what could be called "pull" factors, which originate in the U.S. and tend to attract physicians. One can also cite certain "push" factors, which originate in the home countries and tend to encourage physicians to leave. A general push factor is the tendency of medical schools in underdevel-

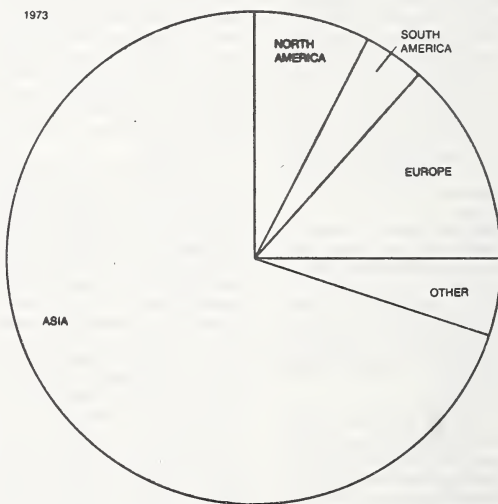
oped countries to pattern themselves after the medical schools in the developed countries of Europe and North America. It is a science-oriented and specialty-oriented training, and a graduate of such a school in an underdeveloped country is therefore predisposed to seek advanced education in places where this kind of training is the norm.

Another type of push factor is specific to the country from which the physician comes. In a survey of foreign medical graduates in the U.S. that my colleagues and I at the Yale University School of Medicine have been conducting for several years the two reasons most often given for emigrating are "Better training in the U.S." (69 percent) and "Political factors" (8 percent). A closely related reason appears to explain why the physician who has left his native country usually does not return, namely his judgment that the possibility of developing a satisfactory practice there is severely limited compared with his prospects in the U.S.

Here one encounters a general problem that has been cited by a number of observers. Although the need for physicians in underdeveloped nations may be substantial, those nations have little capacity for employing physicians. Such a



the U.S. is shown for three years. The charts reflect the region of last permanent residence of the physicians admitted to the U.S. as



immigrants in each year. They also reflect by their relative size the total immigration each year, from 1,990 in 1957 to 7,119 in 1973.

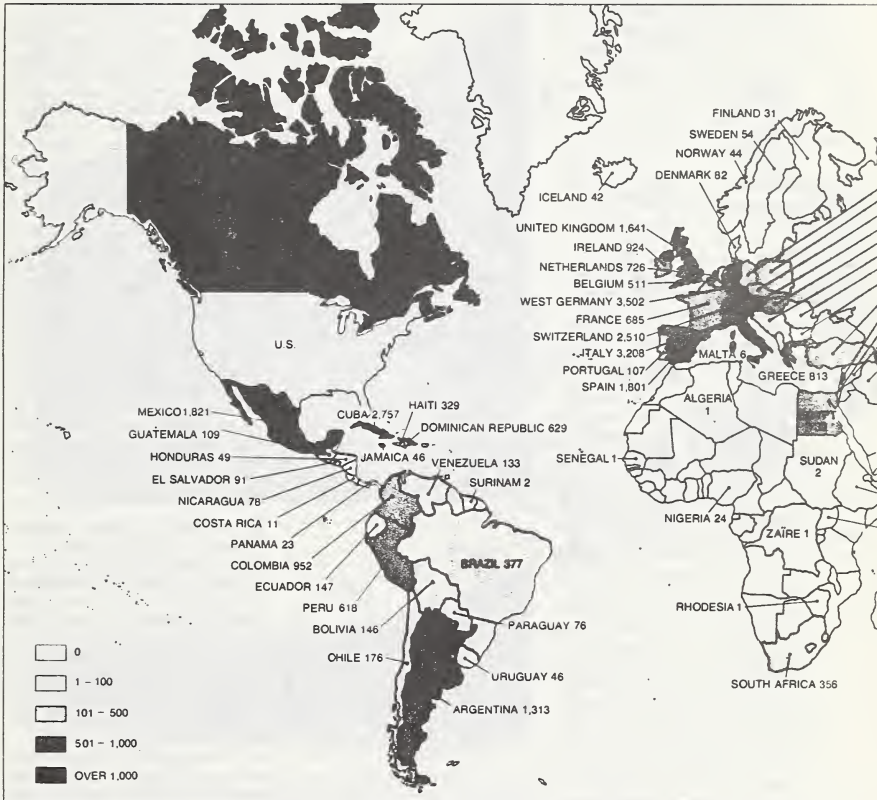
capacity includes several things that the underdeveloped countries have in short supply: an adequate system for delivering health care, sufficient opportunity to advance within the system and attractive economic prospects. Moreover, most physicians would rather work in large cities than in rural areas, and the underdeveloped countries offer too few opportunities for urban practice.

As the flow of incoming physicians began to increase after World War II, demands arose in the U.S. for the establishment of standards of quality to assist

the difficult process of evaluating foreign medical graduates from many nations and from an even larger number of medical schools, which ranged over the spectrum from poor training to excellent training. The first effort in this direction was a list of 39 foreign medical schools, mostly in Europe, drawn up by the Council on Medical Education of the American Medical Association and the executive council of the Association of American Medical Colleges. The criterion for inclusion on the list was that in the judgment of the two groups the schools provided a quality of training equal to

the quality found in most American medical schools.

The people involved in licensing or employing foreign physicians soon found the list to be inadequate, particularly since it consisted mainly of European schools at a time when increasing numbers of foreign medical graduates were from schools outside Europe. As a replacement for the list the Educational Council for Foreign Medical Graduates was established in 1954 by a committee made up of representatives of the American Medical Association, the Association of American Medical Colleges, the



PLACES OF EDUCATION of the foreign medical graduates practicing in the U.S. in 1970 are indicated. At the time some 58,000

physicians who received their medical education in other countries were at work in the U.S. The figure associated with the name of

American Hospital Association and the Federation of State Medical Boards. In 1958 the council began to administer semiannually a standardized examination for all foreign-trained physicians, including the growing number of Americans receiving their medical training abroad.

The examination is in two parts. The first part tests general medical knowledge; its questions are taken from an examination drawn up by the National Board of Medical Examiners and normally given to American students in their fourth year of medical school. The

second part tests knowledge of the English language.

Since the medical questions come from previous National Board examinations and the success of American students in answering each question is therefore known, one can compute the rate at which American students could be expected to pass the council's examination and compare it with the performance of foreign medical graduates. The comparison has always been unfavorable to the foreign graduates. From 35 to 40 percent of them will achieve a passing score on the first try, whereas the "ex-

pected" rate for American medical graduates is more than 90 percent. This comparison is frequently employed to call into question the competence of foreign medical graduates—a point to which I shall return.

As matters now stand, a foreign medical graduate cannot engage in anything more than a limited type of practice in the U.S. without passing the examination administered by the Educational Council for Foreign Medical Graduates. The convention of obtaining the council's certificate is now established, and it represents the major attempt by the medical profession to establish standards for foreign medical graduates. Nonetheless, the council's examination has its critics, who argue that it provides too easy a path for foreign medical graduates and promotes a system of dual standards circumventing the entire process of quality control that is assumed to exist in American programs. As a result, it is argued, the U.S. has a "two-class" medical profession, with American medical graduates constituting the upper class and foreign medical graduates the lower class.

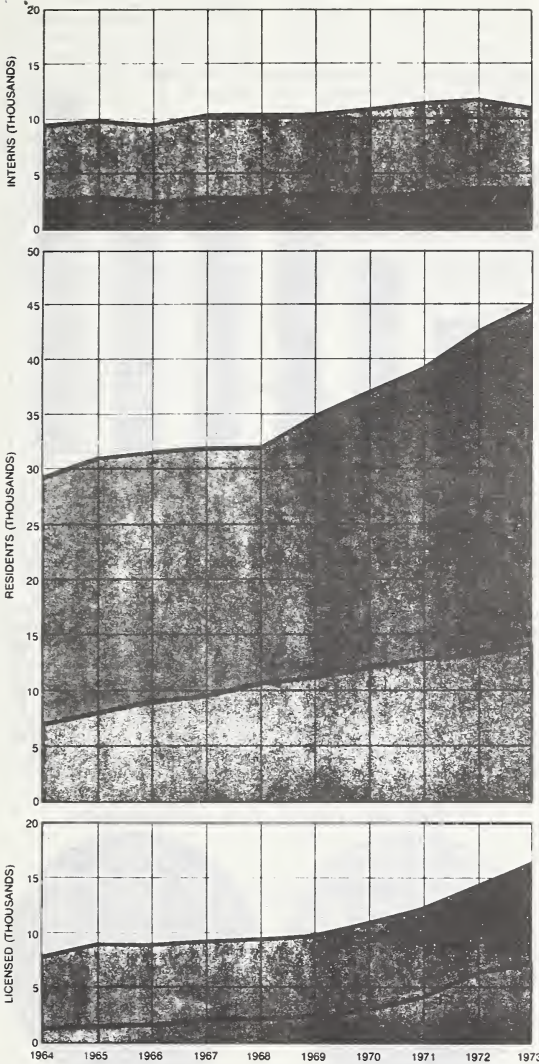
It is certainly true that foreign medical graduates tend to differ from American medical graduates in the roles they fill. They are heavily represented in house-staff positions and among full-time hospital-based physicians. They are underrepresented in private practice and in administrative jobs. Geographically they are heavily concentrated in the Northeast and the Great Lakes states. They fill definite shortages in urban environments and in nonaffiliated hospitals, that is, hospitals without ties to medical teaching programs. With certain exceptions the patterns seem to support the two-class hypothesis.

All the foregoing remarks constitute what I have intended to be a descriptive section of this article. I now turn to more argumentative matters concerning the current debate over foreign medical graduates and the various assertions that they constitute a problem. It is not entirely rhetorical to ask if there is, in fact, a problem. As sociologists have pointed out, what may constitute a problem for society and what is defined as a problem are not necessarily the same.

A statement that summarizes the views of the people who see foreign medical graduates as a problem was made at the 1972 meeting of the American Psychiatric Association by E. Fuller Torrey and Robert L. Taylor, who are



each country shows how many of those physicians received their medical degree in that country. Major sources can be identified at a glance by means of the shading on the map.



TEN-YEAR TREND in the number of graduates of medical schools in the U.S. (gray) and of foreign medical schools (color) beginning practice in the U.S. is charted. The top chart reflects the number of physicians employed as interns, the middle chart the number employed as hospital residents and the bottom chart the number obtaining a license from a state to practice medicine. The two curves in each chart are cumulative, so that by reading them together one can arrive at the total number of physicians in each category each year.

American-educated physicians. Their title was "Cheap Labor from Poor Nations." The argument, which relates to psychiatrists but can by extension be applied to all types of foreign medical graduates, runs as follows.

Foreign medical graduates practice in institutions (such as city hospitals, prison hospitals, state hospitals and institutions for the mentally retarded) that American psychiatrists regard as undesirable. The reasons are inaction and lack of planning by Federal agencies and professional associations. Federal agencies spend money on medical training with too much emphasis on increasing numbers of physicians and too little on the problem of how they are distributed. Moreover, the foreign medical graduates are deficient in English and in acclimation to American culture, and many of them are not up to American standards of medical proficiency. Finally, the professional associations have rigidly upheld out-of-date standards that restrict professionals other than physicians from providing psychiatric care.

The final comment appears to be at odds with the suggestion that foreign medical graduates are often poorly qualified to deliver psychiatric care. It reveals, however, what we believe is the reason for the agitation expressed by Torrey and Taylor and for the wider criticisms of the nation's heavy reliance on foreign medical graduates of all types. The reason is the realization that the growing presence of foreign-trained physicians is symptomatic of wider problems in the American system of delivering health care. Associated with this realization is the recognition that the medical profession as it has been structured since the reorganization of medical education following the Flexner report of 1910 (*Medical Education in the United States and Canada*) is under severe pressure to change. Allegations of inequities in the delivery of care, of discriminatory admissions policies by medical schools against women and racial minorities, of a disjunction between academic medicine and the effective delivery of medical care, of self-interest of physicians and their professional associations and of an overriding failure to plan systematically have all taken their toll. The evidence of these shortcomings is the foreign medical graduate, who has helped to maintain a faltering system by disproportionately filling the roles that American-trained physicians regard as least desirable.

Two international organizations have been studying the migration of health professionals. The World Health Orga-

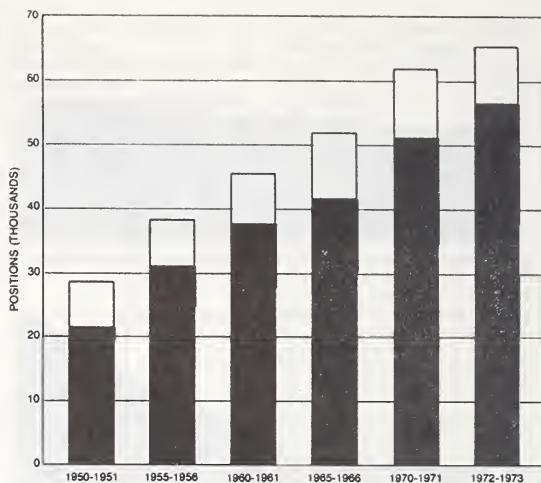
nization recently began to examine the causes and consequences of the migration and to assess its true magnitude. The Pan American Health Organization has sponsored several conferences on the migration as it relates to Latin America. No definite results or policy recommendations have yet emerged from these activities.

The situation within the U.S. is best described as bizarre. Although the Federal Government gives the appearance of activity, its movements seem contradictory. A year ago Charles C. Edwards, assistant secretary for health in the Department of Health, Education, and Welfare, asserted that \$3.5 billion of Federal spending over the past decade had eased the physician shortage and that the U.S. "may well be facing a doctor surplus." On the other hand, the Department of Labor operates as if a physician shortage existed. As the agency charged under the Immigration Act of 1965 with declaring what occupations are understaffed in the U.S., the department has unflinchingly kept physicians and other health professionals on the list. As a result they encounter minimal problems in gaining entry to the U.S.

The major professional organizations have also had difficulty articulating a position on foreign medical graduates. In a report published last August the Association of American Medical Colleges called for a reduction in the number of foreign-trained physicians (including Americans) and for an end to dual testing and evaluation standards, meaning that foreign medical graduates should take the same route (presumably a more difficult one) that American medical graduates take to qualify for internships, residencies and practice. The report also urged maintenance of the present standards of delivering health care, although how that could be done while the number of foreign medical graduates was being drastically reduced was not explained.

The crucial question in this report, as in other reports and in Congressional hearings and journal articles on foreign medical graduates, is the competence of foreign medical graduates and to what degree it differs, if at all, from that of American medical graduates. An examination of this issue reveals certain less obvious concerns behind the stated concern over competence. The examination also brings into sharper focus the role of foreign medical graduates in the broader picture of changes in the American system of health care.

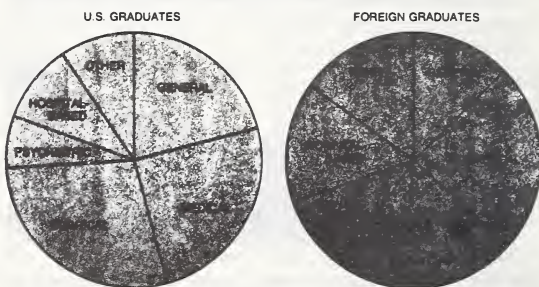
A statistic often cited to question the



STAFFING OF HOSPITALS has relied increasingly on foreign medical graduates in recent years. Each whole bar on the chart shows the number of interns and residents that hospitals in the U.S. sought to employ in each of the years indicated. Shown within that total are the number of those house-staff positions filled by American medical graduates (gray) and by foreign medical graduates (color) and also the number of positions unfilled each year.

competence of foreign medical graduates is their record in obtaining state licenses to practice medicine. For example, calculations we made on the basis of a survey by the American Medical Association (designed to ascertain what all the people who had been interns and residents in 1983 were doing in 1971) showed that 93 percent of the American medical graduates and 66 percent of the

foreign medical graduates had obtained licenses. A close look at data of this kind, however, suggests that too many factors other than competence are associated with licensure to warrant its use as an unbiased measure of competence. For example, one finds a strong correlation between the type of visa a foreign medical graduate holds and his ability to obtain a license. People who had become



CHOICE OF SPECIALTY is depicted for graduates of American medical schools (left) and for foreign medical graduates in the U.S. (right). The data are for 1970. Among "medical" specialties are cardiology, dermatology, internal medicine, pediatrics and work with allergies. Among "hospital-based" specialties are anesthesiology, radiology and pathology.

U.S. citizens through the naturalization process were licensed at the same rate as American medical graduates, immigrant physicians at a slightly lower rate and exchange visitors at the lowest rate. There is no a priori reason related to competence why these differentials should exist.

It is instructive to see how native Americans who took their medical training abroad fared in licensure. Examining the 10 countries that educate the greatest number of Americans, one finds that (with two exceptions) the graduate's ability to obtain a license in the U.S. is higher for the Americans than it is for native students being graduated from the same school. Here the medical-school

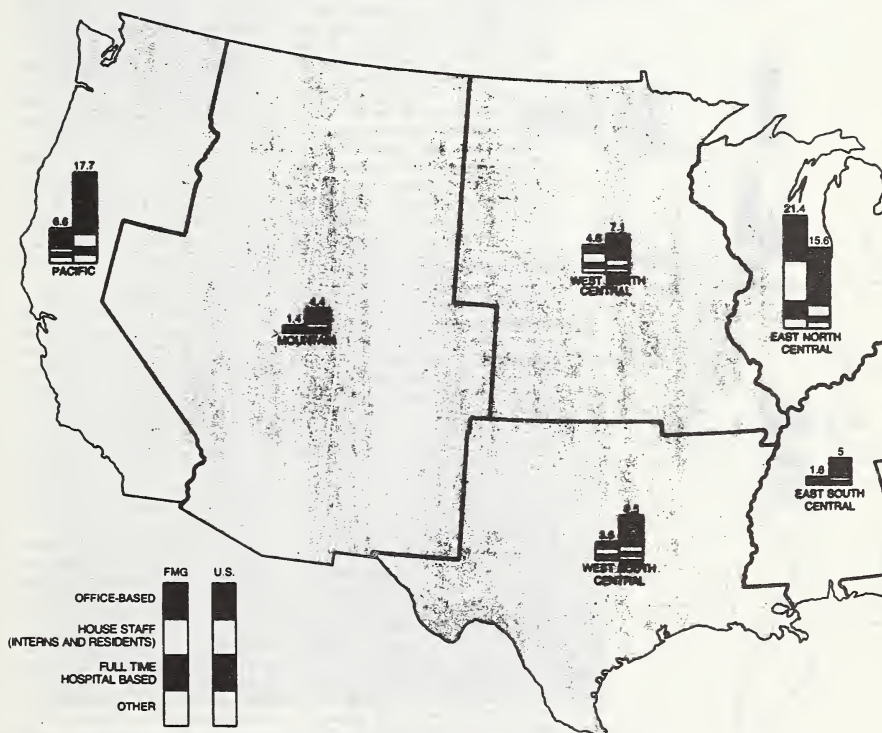
background is equivalent for each type of applicant.

One can turn the picture around and examine the few foreign-born physicians who have been trained in American medical schools. Again one finds that the pattern of licensure varies according to the type of visa held by the applicant. Evidently administrative factors have as much bearing on the ability of a foreign medical graduate to obtain a license as the quality of his medical degree does.

What of the statistics showing that foreign medical graduates score more poorly on the examination given by the Educational Council for Foreign Medical Graduates than American medical students could be expected to score, based on their performance on the ex-

amination given by the National Board of Medical Examiners? It is noteworthy that Americans who study medicine abroad are even less successful than foreign medical graduates in passing the council's examination but are as successful as American medical graduates in obtaining licenses.

In addition to their record on the council's examination foreign medical graduates do not fare as well as American medical graduates on the examinations administered by the various medical boards that certify physicians for such specialized types of practice as orthopedic surgery and ophthalmology. A conclusion usually drawn from such statistics is that foreign medical schools are by and large of lower quality than Amer-



DISTRIBUTION OF PHYSICIANS in the U.S. is portrayed according to whether they were educated in U.S. (gray) or foreign

medical schools (color) and according to type of practice. The figure at the top of each bar is the percentage of each type of graduate

ican schools. Another conclusion is that one cannot cite language as a barrier for foreign medical graduates, since Americans who studied abroad fare even more poorly on the council's examination than foreign medical students.

It would take further study, however, to determine whether or not these conclusions are justified. Perhaps Americans who go abroad to study medicine represent a significantly less qualified pool of physicians than foreign medical graduates. An even more plausible supposition is that, although foreign medical graduates have language problems that impair their performance on an examination such as the one the council gives, Americans who study abroad suffer from language difficulties while they are learning

medicine, resulting in deficiencies that may never be overcome and that manifest themselves in examination scores. As for the poorer record of foreign medical graduates in obtaining certification from specialty boards, no one has disproved the hypothesis that a contributing factor is the large number of foreign medical graduates who receive graduate training in American hospitals that are not affiliated with teaching centers.

I am not arguing here that all the data on foreign medical graduates are false or that no real differences exist between the foreign graduates and American medical graduates. My point is that quality of care and being a foreign-trained physician may be correlated only under certain specific conditions. In fact, I am suggesting that no correlation can be demonstrated because no uniform procedures for measuring quality of care have yet been proposed, let alone applied to foreign medical graduates.

Analysis of our group's National House Staff Survey shows that foreign medical graduates occupying house-staff positions have had significantly more clinical practice (before arriving in the U.S.) than their American counterparts, most of whom go directly from medical school to a house staff. It may be that in terms of experience the foreign medical graduate is able to deliver better care to the patient than the American graduate, although language, cultural differences and hospital experiences may detract from the foreign graduate's performance. Indeed, if there is a "problem" involving foreign medical graduates, the problem may be that a valuable manpower resource is being underutilized in the nation's health-care system.

If the issue of competence is as clouded as I have indicated, what other factors might account for the current climate of concern about foreign medical graduates? The roots, I believe, are to be found in economic and political considerations. The Nixon and Ford administrations have made clear that an accounting of the large Federal investment in medical education is expected. Various officials of the Department of Health, Education, and Welfare have strongly implied that there will be cuts in spending.

The continuing presence of foreign medical graduates may be a powerful weapon for the Government against arguments that Federal funding should not be cut and should even be increased. When the argument is raised, the Government can counter that the corps of foreign medical graduates reduces the

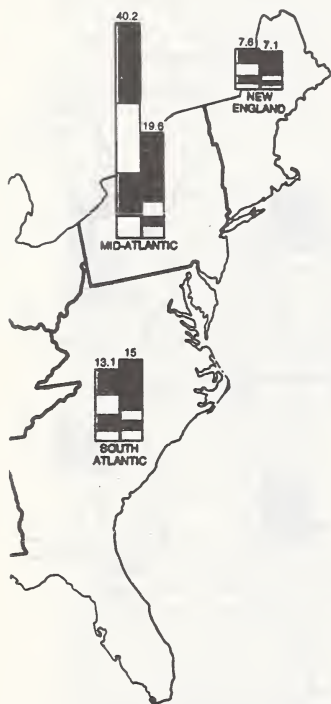
need to educate more American physicians. The countervailing argument, which is advanced mostly by professional medical organizations, fits neatly with the assertions that the foreign graduates may be delivering substandard care. By calling into question the quality of the foreign graduates, the arguer can contend that more money rather than less is needed to educate more American physicians to take over the places now occupied by foreigners.

From the point of view of the foreign medical graduates it must be difficult to understand some of the attitudes they encounter. The foreign graduates have been welcomed to the U.S. through lenient regulations on visas. In some cases they were actually recruited by representatives of American hospitals. Yet once here they are attacked as being less competent than American physicians.

In this situation the foreign medical graduate has become a pawn among warring factions in a medical profession that is caught up in ambivalence over what to do about changing the system of health-care delivery in the U.S. Lacking a coherent policy regarding the numerous issues in medicine, the medical profession in the U.S. has allowed the foreign medical graduate to fill in the most obvious cracks in the system. Once here, however, the foreign graduates have their own interests to protect.

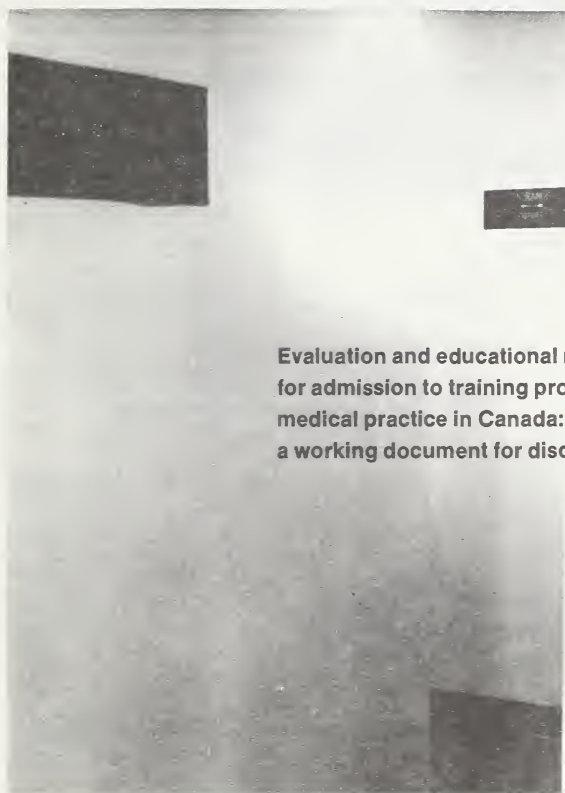
Meanwhile the problems of the countries from which the foreign medical graduates came remain unsolved. Indeed, it can be argued that these problems are being intensified as a result of a decline in the amount of foreign aid provided by the U.S. Foreign medical graduates understandably express reluctance to return to their home countries unless those countries develop better systems of health care. Improvement is unlikely to be rapid in any case, but with lower levels of foreign aid from the U.S. it may be even longer in coming.

The answers will not be found easily. Because of the large number of licensed foreign-educated physicians who have become naturalized citizens of the U.S., it is easy to predict that foreign medical graduates will continue to play an important role in the nation's health-care system. It is more difficult to predict whether this dependence on foreign medical graduates will continue to increase or whether it will decrease under the pressure of the complaints raised about it. It may not be possible for other nations to solve their problems regarding medical manpower until the U.S. has solved its own.



in each geographical region. Distribution by type of practice is indicated within the bars.

The graduate of the foreign medical school



**Evaluation and educational requirements
for admission to training programs and
medical practice in Canada:
a working document for discussion**

P R E F A C E

This paper was approved by the CMA General Council on June 24, 1975 as a document to be used in discussions with appropriate education, licensing and governmental agencies for further study and development. The recommendations on pages 5 - 7 are not official CMA policy at the present time.

Although not official CMA policy, this working document is being published at this time so that maximum input from all appropriate agencies can be considered prior to the formulation of definite policy and recommendations. Up to now, Canadian immigration authorities, provincial licensing authorities and postgraduate training programs have not dealt in an integrated fashion with the educational problems of graduates of foreign medical schools.

It is hoped that distribution of this working document will lead to fruitful discussions and feasible solutions to the extensive and complex problems associated with the entrance into the Canadian health system of graduates of foreign medical schools.

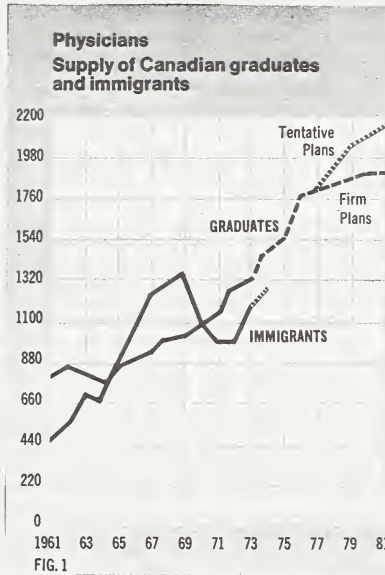
J. L. Chouinard
Director
Medical Education
Canadian Medical Association

September 1, 1975

- 1 -

In the last few years there has been an increasing interest in the issue of immigration.(1) In the medical field, the interest has focused on the particular problems of the impact of immigrant physicians on Canadian medical schools, postgraduate training programs, and medical care in general.(2) The intent of this brief is to suggest some possible solutions to the problem of the disparity of education and evaluation between foreign-trained and Canadian-trained physicians.

Canada has, for many years, drawn heavily upon graduates of foreign medical schools (GFMSs) to augment its physician manpower needs. (Table 1, Figure 1)



Source: Hacon & Aziz, Canadian Medical Association Journal; 112:519, 1975

From 1966 through 1970, the number of physicians migrating to Canada exceeded the number produced by our own Canadian medical colleges. In 1974, about one third of all physicians in Canada (11,244) were graduates of foreign medical schools.(3) The number of graduates of Canadian medical schools is increasing because of expansion of existing medical colleges or creation of new ones, but immigrant physicians still constitute a very large proportion of newly licensed physicians in Canada each year. This influx of GFMSs to help fill manpower needs has, in recent years, caused governments, universities and postgraduate medical training programs in Canada to try to fulfil the need to further expand Canadian programs to provide all the physicians we need from our own population. A marked increase in output capacity of Canadian medical schools has been brought about by the Health Resources Fund program.

Initially most GFMSs came from European or other well developed countries, whose medical schools provided training comparable in quality to our own. In recent years, increasing numbers of GFMSs are migrating to Canada from Asian and other developing countries, whose medical schools have no uniform program of postgraduate training evaluation. This has created problems for their country of origin, for them and for Canadian medicine. From the standpoint of their own countries, the GFMSs who emigrate represent a loss of money invested and, in some countries, a loss of manpower badly needed. The GFMS, arriving in Canada, has to cope with a vastly different culture and medical system than those of his or her own country and faces a confusing variety of provincial licensing requirements which vary from province to province.

The GFMS, particularly one from a developing country, presents an educational enigma in Canada. He or she gains access to positions in medical care programs without the same rigorous evaluation the Canadian medical school graduate undergoes at the undergraduate level and, to some degree, the postgraduate level as well. This has led to problems resulting from varied educational backgrounds, specialization, and lack of comparison with Canadian medical school graduates. There have been improvements in assessing the educational needs of the GFMSs, primarily due to cooperation by various interested organizations, but there are still many difficulties to be resolved.

The majority of GFMSs tend to gain admission into intern training programs which are either new or not as well recognized as others in Canada. They are competing with more fortunate (from the standpoint of medical education) Canadian graduates for postgraduate medical training positions in Canada. This results in a disproportionately high number of GFMSs in these programs. Within these programs, this creates difficulties due to the varied backgrounds of GFMSs, and the insufficient numbers of Canadian graduates to be measured against. It makes their evaluation and education difficult. Thus, the educational result may be inferior to that provided by well established programs.

What needs to be done to cope with the problems outlined above? Basically, we need to project manpower needs for the foreseeable future and then prepare our own medical colleges to meet these needs. (See note p.10) We must recognize this will not happen quickly and we may still be dependent for some time on foreign countries to contribute to our medical manpower. We should, therefore, ask ourselves three questions:

1. *Are we adequately evaluating graduates of foreign medical schools who apply to this country for further medical training or practice?*

At present, category I GFMSs^{*} with an internship in their country are accepted by some provinces for licensing purposes almost on a par with our Canadian graduates. They do, of course, have to fulfil some postgraduate requirements for training before they can be licensed to enter into independent practice. There are still instances, however, where the category I GFMSs gain entrance into practice owing to reciprocity without further training or evaluation.

The category II GFMSs^{**} are required to be graduates of a medical school listed in the "World Directory of Medical Schools" and to hold a certificate of the Educational Commission for Foreign Medical Graduates (ECFMG) to show they have passed the ECFMG examination before being allowed into Canada. Provincial licensing bodies specify the length and, to some extent, the content of the internship program that the GFMSs must take in Canada. However, in most instances neither the training programs nor the provincial licensing bodies make a concerted effort to implement training requirements that take into account the special educational, language and cultural needs of these GFMSs to help them integrate better into Canadian society and medicine.

The ECFMG examination is not capable of assessing the basic medical knowledge of the GFMSs to the same extent as the examinations taken by our own Canadian medical school graduates.(4,5,6,7) It is, of course, not the intent of the ECFMG examination to do this. However, it had been hoped that the examination would identify GFMSs who would benefit from further medical education in the United States or Canada. It has not succeeded in doing this satisfactorily. In addition, the language evaluation portion of the ECFMG exam is seriously deficient as an effective means of ascertaining the foreign graduates' command of English.(8,9) The ECFMG exam does not attempt to evaluate the GFMSs' ability to communicate in French.

The overall failure rate of category II GFMSs on the Medical Council of Canada examination has been exceptionally high compared with that of Canadian graduates and graduates of category I medical school. (Table 2) These category II graduates have passed the ECFMG exam, have been accepted into Canadian postgraduate training programs, and have then taken the Medical Council of Canada examination after at least one year of postgraduate training. It appears, then, that their basic medical training does not adequately prepare the category II graduate for this examination.

We believe that we are not adequately evaluating graduates of foreign medical schools, and this presents Canada with an as yet unresolved educational challenge.

* Graduates of medical colleges in USA, United Kingdom, Eire, Australia, New Zealand and South Africa

** Graduates of medical colleges in countries other than above, recognized for training of medical practitioners by the World Health Organization.

2. *Having accepted a graduate of a foreign medical school for training, do we not owe it to him or her to see that the training takes into account any basic deficiencies in his or her previous training in medicine, cultural differences and problems stemming from an inadequate background in the English or French language?*

We have already alluded to this problem above. Considering the various language, cultural and social milieu from which physicians emigrate, post-graduate medical training programs should be devised in such a way that they take into account, where necessary, the special needs of the GFMS. In medicine, the ability to communicate and understand is paramount. Up to now, immigration authorities, provincial licensing authorities and postgraduate training programs have not dealt in an integrated fashion with this problem.

We feel, then, that we owe the graduate of a foreign medical school the opportunity to train in programs that are better able to recognize his or her basic weaknesses and needs. We should then take steps to correct his or her basic deficiencies before plunging him or her fully into the same program of training as our own Canadian medical school graduates.

3. *Should we not expect the foreign medical school graduate to undergo evaluations which place him or her on a par with our own Canadian trained physicians, before he or she is permitted to practise independently?*

Some GFMSs, who are not fully qualified or fully licensed by examination, are practising (usually in institutions, but in some cases in private practice) either independently or without adequate supervision. Some of these graduates have proven themselves quite competent, but there are others who have not done so or who have never had their work effectively evaluated to see whether they are performing competently or not. This has given rise to a "second class" variety of physicians in Canada, one certainly not desired by the GFMSs, and positively not good for the practice of Canadian medicine.

In summary then, we believe that the graduate of a foreign medical school should satisfy the same evaluation and licensing requirements as the Canadian graduate before being permitted to enter independent or unsupervised medical practice.

RECOMMENDATIONS:

The solutions to the problems outlined above will not be easily found or implemented. To be lasting and just, they will require a cooperative effort between educational, licensing and governmental agencies and the medical profession. A start must be made, however, and it is reasonable to assume that 5 to 10 years will be required to bring about significant changes.

With this in mind, the following recommendations are made:

Recommendation I

That as soon as possible, present studies and projections for medical manpower requirements and distribution in Canada be completed. We are particularly interested in the implications of these projections for the future need for graduates of foreign medical schools in this country.

Recommendation II

That the facilities of Canadian medical schools be adjusted to meet the medical manpower requirements of areas or specialties presently underserved.

Recommendation III

That more effective means of screening the graduates of foreign medical schools who wish to enter Canada for further training or to practise be developed. Areas of evaluation should include not only medical knowledge and clinical competence but also ability to communicate in the English and/or French language. We recommend the following:

- a) that existing reciprocity agreements be discontinued;
- b) that all graduates of foreign medical schools seeking to immigrate to Canada for further medical training and/or practice, or seeking to come to Canada with a visitor's visa for further medical training must first pass a "Part A equivalent" examination of the Medical Council of Canada. To facilitate this procedure the Medical Council of Canada would establish examination centres in various parts of the world;
- c) that on arrival in Canada they would be given a personal interview and examination in basic English or French as appropriate to their desired location, and be evaluated in their ability to adjust and communicate in the Canadian socio-cultural and medical milieu;

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- d) that those found to be acceptable after this evaluation would be given an Enabling Certificate to sit Parts A and B of the Medical Council of Canada examination, and could be temporarily licensed if they have satisfied all the other training requirements of the licensing body in the province in which they wish to train or practise;
- e) that all others would undergo an orientation program to include special language, socio-cultural and general medical immersion. These programs should be developed by the Department of Manpower and Immigration in consultation with licensing authorities and educational bodies. During this period, arrangements should be made for the foreign graduate to be financially supported by the Department of Manpower and Immigration. (See CMA Brief to Canadian Immigration and Population Study, Dec. 1973)

After satisfactorily completing this orientation program, the graduate of foreign medical schools would enter an appropriate, nationally approved training program and be given the opportunity of sitting Parts A and B of the Medical Council of Canada examination.

After satisfying provincial licensing requirements and passing Parts A and B of the Medical Council of Canada examination, he or she would then be eligible to pursue appropriate medical practice or further postgraduate training of his or her choice.

- f) that in order to assure an even distribution of these graduates, at this stage, in the various postgraduate training programs in Canada, not more than 30% and not less than 10% of the post-graduate training program enrolment should be graduates of foreign medical schools.

Canada must, however, still recognize its position re refugees who are expelled or leave their countries of residence as a result of a crisis. The general open-arms policy of Canada in the past, with respect to refugee physicians, must be maintained.

Recommendation IV

That pilot studies be developed that can be utilized by all training programs accepting graduates of foreign medical schools to define ways of identifying basic deficiencies they may have, and the means of correcting these before moving them into the full postgraduate training programs to which Canadian medical school graduates are exposed.

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Recommendation V

That provincial licensing bodies move to develop, in cooperation with existing postgraduate training programs, educational and evaluation procedures to upgrade and certify competency of graduates of foreign medical schools presently not fully licensed, but who are in independent or unsupervised practice in Canada.

Recommendation VI

That the Federation of Provincial Medical Licensing Authorities of Canada, along with the appropriate educational agencies, develop uniform and nationally portable requirements for training and licensing graduates of foreign medical schools.

Recommendation VII

That Canada continue to admit graduates of foreign medical schools who, because of special expertise or renown, would benefit themselves or Canada through educational or research activities, and who would have a defined licence to practise in their area of expertise. These graduates would not have to go through the same requirements as others wishing to train or practise in Canada, but rather should be judged on individual merit by the appropriate provincial licensing body.

Recommendation VIII

That special arrangements should be made for selected programs to be developed at medical schools that would be more appropriate for the graduate who comes from a medical school in a developing country for training in Canada, with the intention of returning to his or her native country.

Recommendation IX

That Canada expand present aid programs to developing countries by providing additional teachers and facilities for physician training in these countries.

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TABLE I

GRADUATES - CANADIAN MEDICAL COLLEGES *		IMMIGRANT PHYSICIANS PHYSICIANS TOTAL		NET GAIN
<u>Year</u>				
1963	818	687	1505	834
1964	787	668	1455	765
1965	835	792	1627	659
1966	888	995	1883	1047
1967	923	1213	2136	1016
1968	1016	1277	2293	735
1969	1016	1347	2363	1380
1970	1070	1113	2183	1528
1971	1152	987	2139	1480
1972	1279	988	2267	1883
1973	1326			
1974	1561 (1)	1200 (2)		
1975	1572			
1976	1768			
1977	1771			
1978	1785			
1979	1853			
1980	1883			
1981	1883			
1982	1883			
1983	1883			
1984	1883			

* Numbers of Graduates from Canadian medical colleges to 1974, and projections to 1984 provided by the Association of Canadian Medical Colleges.

(1) The large increase was due to a double graduation from Dalhousie University (who abandoned its five (5) year curriculum in 1974) to an increase in student enrolment in 1969-1971.

(2) Estimation, Hacon and Aziz, Can Med Assoc J, 112: 514, 1975

Note that the projected number of graduates remains constant from 1980 onwards owing to lack of trend forecasting data. Also, during the last three years the output has increased well above the level anticipated.

TABLE 2

Number of Physicians writing the Medical Council
of Canada Examinations with percentages of those
obtaining a full pass*

YEAR	CANADIAN GRADUATES	FULL % PASS	CATEGORY I GFMSs	FULL % PASS	CATEGORY II GFMSs	FULL % PASS
1963	608	91.9	102	66.7	187	30.5
1964	592	94.6	118	81.4	181	41.4
1965	649	94.1	140	78.6	191	35.0
1966	747	96.0	177	76.3	201	44.3
1967	678	93.5	254	72.4	188	44.1
1968	799	95.2	219	68.9	173	55.5
1969	838	99.4	382	90.0	350	75.1
1970	890	95.6	394	73.9	698	51.9
1971	1056	93.0	384	81.8	715	60.0
1972	1345	95.5	457	92.1	611	81.2
1973	1307	87.8	438	83.6	526	56.1
1974	1439	89.2	505	76.0	510	49.0

Sources: Annual Announcements - Medical Council of Canada - 1964 through 1974 inclusive.

* The figures given are for candidates who tried both Part A and Part B of the examination, and do not include those persons who attended re-examination in Part A or Part B only.

Note: The National Physician Manpower Committee and its subcommittee on physician manpower requirements is currently developing criteria and will be making recommendations regarding future requirements for physicians in Canada. The present studies raise the question of the prediction that no graduates of foreign medical schools will be necessary if the physician : population ratio of 1 : 600 is to be the guideline. The current policy of requiring these graduates to be directed to areas and specialties of greatest need, however, is all the more reason to upgrade and ensure their educational background.

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NASA

Universidad Autonoma de Guadalajara



Northamerican Autonomous Students Association

APARTADO 5-403 GUADALAJARA, JALISCO, MEXICO.

October 10, 1975

Mr. Lee Goldman
 Legislative Assistant
 Senator Kennedy
 Senate Office Building
 Washington, D.C.

Dear Mr. Goldman:

On behalf of the officers and the approximately two thousand five hundred United States citizens who are members of the Northamerican Autonomous Student Association at the Universidad Autonoma de Guadalajara, I welcome this opportunity to voice our support of Senate Bill 989, an amendment to the Public Health Service Act.

We appreciate very much the provisions this bill includes for U.S. citizens studying medicine and dentistry in foreign countries. We particularly feel that Title III, Section 747 concerning loans to U.S. citizens studying medicine and dentistry in foreign countries fills a current and vital need. As you know the Federal Guaranteed Loan Program, provided for by the Higher Education Act of 1965, is the only active federal program supporting medical and dental students studying in foreign countries. However, the total ten thousand dollar maximum limit provided by the Guaranteed Loan Program is less than is required to support a medical student here for only one year, and many needy students have used almost their limit by the time they finish their undergraduate study. The Universidad Autonoma de Guadalajara administers no loan or grant programs for United States students. We therefore feel that many students here will be glad to trade a service obligation in a physician shortage area for the financial support bill S-989 provides.

For the same reasons as stated above we also feel very strongly that the eligibility requirements under Section 750, "Public Health and National Health Service Corps Scholarship Training Program", be amended to include provisions which would allow

Mr. Lee Goldman

2

October 10, 1975

United States citizens studying medicine or dentistry in foreign countries to participate.

We support Title V, "Assistance for Specialized Training", Section 767, "Grants for Training, Traineeships, and Fellowships in Family Medicine". Because of our training in the Spanish language and Latin culture we are in a unique position to serve in hospitals in many areas of the U.S. where substantial portions of the population are Spanish speaking.

We would like to have this read into the record as the official NASA position of Senate Bill 989.

I appreciate the interest you have shown and the help and information you have personally provided in the past. Thank you again for your assistance.

Sincerely,

Barton Moore
Barton Moore
NASA Secretary

THE UNITED STATES OF AMERICA, AN OMNIVEROUS MECCA:

FOREIGN MEDICAL GRADUATES AND INTERNATIONAL LAW

Phil R. Aaron, M.D.
21 December 1975
502-451-7486

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I. The Foreign Medical Graduate

Robin Hood in Reverse: Stealing from the poor to give to the rich.

It is no longer the call to 'Give me your tired, your poor, your huddled masses'. Now we ask for your alert, your privileged, your brainy, your talented.

The overall work force in the United States has always been substantially affected by immigration. The medical profession has not been an exception. Today, however, the arrival of physicians educated abroad (foreign medical graduates) and their integration into the U.S. system of medical training and practice have reached alarming proportions.

Nationwide, one out of every four licensed physicians, one out of every three house officers (interns and residents), one out of every three hospital based physicians, and one out of every three physicians conducting research is an FMG.¹ There are more Filipino physicians in the U.S. than there are black physicians,² and more Iranian doctors in New York than in all Iran.³ FMGs comprise more than 50% of the house staff in more than 42% of the hospitals offering residency positions.⁴

In a little over a decade the rate of increase in the number of FMGs in the U.S. has been four times greater than the rate of increase in the total physician supply.⁵ In 5 of 7 years through 1973 more graduates of foreign medical schools entered the U.S. than physicians were graduated from our own medical schools, and one-half of all newly licensed physicians in 1972 and 1973 were FMGs.

The number of FMGs entering the U.S. annually has increased from 1,040 in 1954 to 12,850 in 1973.

And, there has been an 860% increase in the number of FMG house officers from 1950 to 1970. The ratio increased from 10:1 US:FMG house officers in 1950 to 2:1 in 1970.⁶

As a consequence of the significant increase in sheer numbers of FMGs, (80,000 are now in the U.S.), certain problems have resulted. FMGs even more than USMGs gravitate toward urban areas. In 1970 less than 10% of all FMGs were found in nonurban locations. We find that 60% of New York City's housestaff and 78% of New Jersey's housestaff are FMGs.⁷ In seven states FMGs accounted for 75% of all new licenates in 1973 while in 1950 FMGs had only accounted for 10% of all new licenates.⁸ This concentration of FMGs in doctor rich areas of the U.S. magnifies and multiplies the maldistribution of U.S. physicians.

Many FMGs are deficient in English, are not acclimated to American culture, and are not proficient in the practice of medicine by American standards. By having less medical competence than U.S. medical graduates, FMGs "dilute" the quality of U.S. health care delivery. Congressman William Roy, M.D. (D.-Kansas) discussed these deficiencies in a hearing before the U.S. House of Representative's Health subcommittee,

May I suggest to you as a physician that it is extremely difficult to deal with the patient population unless you know something of their background, something of their culture, something of their mores, and that the FMGs almost without exception fall short in this area.⁹

Before 1965 most FMGs came from other countries in the Western hemisphere. Since 1965 Asian countries have dominated in providing FMGs—mainly as a result of changes in the Immigration Act of 1965.

With most FMGs now coming from Asian countries, alarming problems exist today due to the FMG's inability to communicate, to understand American culture, and to effectively participate in the delivery of medical care.

American medical schools are annually turning away over 20,000 qualified applicants. Two qualified applicants are rejected for each applicant accepted. Seen in the context of America's inability to significantly increase the number of native trained physicians, the great influx^{of FMGs} is interpreted by some authorities as a mere market response to a severe shortage of physicians in the United States.¹⁰

During the period 1948-1970 the population of the U.S. increased 40%. During this same period the increased output of U.S. medical schools plus FMGs boosted^{the} physician ratio per 100,000 population from 128 to 150. Excluding the FMGs there would have been 126 physicians per 100,000 population — less than the ratio existing in 1948!¹¹

The FMG comes here for better training, then does not go back to his own country because he has better medical prospects in the United States. This is because many developing countries do not have:

- (1) advanced health care delivery systems
- (2) opportunities to advance within these systems.¹²

Once here however, the FMG fills in a disproportionately high number positions that American trained physicians regard as least desirable. Many FMGs for example handle service functions ("scutwork") in state mental and penal institutions.¹³

Between 1901-1910 only 1% of U.S. immigrants were professionals. Between 1961-1970, this number rose to 10.2%.¹⁴ These trends have caused concern with respect to U.S. foreign policy, in part because the large number of FMGs entering and remaining in the U.S. represents a loss of scarce manpower from less developed countries that have greater needs than the U.S. for these physicians.¹⁵

The point is that we are relying in great part upon physicians from foreign countries to supply the health manpower needs of the United States. Many of the foreign countries so affected see these physician migration patterns as a physician "brain drain" of one of their most important and expensive natural resources. It has been estimated that the 80,000 FMGs in the U.S. would have cost \$8,640,000,⁰⁰⁰ to produce from native stock in U.S. medical schools.¹⁶

In general the countries contributing the largest number of physicians to the U.S. have the fewest physicians available for their own populations. The less developed countries are educating thousands of physicians who ultimately practice in what is perhaps the most developed and physician-rich nation of all. In the United Nations, the representative from Dahomey described this process as it related to his continent as an "odious

bleeding" of Africa, a continuation of the slave trade.¹⁷

An official in the U.A.R.'s ministry of education gave his country's reaction,

The U.A.R. is of the opinion that the 'brain drain' processes are immoral processes which impair nation-building efforts in developing countries by depriving them of the required human experiences and thus hamper their march toward progress ...the 'brain drain' policy adopted by certain advanced countries to drain qualified elements from the developing countries is against the principles and purposes of international cooperation.¹⁸

Since the United States has become dependent on FMGs as a source of health care providers, it is not impossible that Asian nations could turn off the spigot of our health manpower supply just as middle East countries did our fuel supply.¹⁹

II. Immigration Laws

6

The immigration laws of the United States are among the worst, longest, most ambiguous, complicated, illogical, undemocratic, and arbitrary laws in the world ...our immigration statute and the procedures prescribed under it are far too complicated, oppressive, obsolete and unyielding ...the law is unjust, unfair, capricious and arbitrary in the handling of aliens.²⁰

The population of the United States grows 400,000 per year through immigration. Selection of the best trained applicants can cause problems with both domestic and foreign policy goals.²¹

In addressing physician migration patterns the crucial factor is the emigration policy of the developing country and the immigration policy of the developed country: The stricter of the two policies determines the magnitude and direction of the flow.²² This is most evident when analyzing the immigration policy of the United States. A liberalization in these laws dramatically increased the number of FMGs coming into the United States.²³

IMMIGRANTS

The October 3, 1965 amendment (p.l. 86-236) to the McCarran-Walter Immigration Act replaced the racially discriminatory, nation quota system with a more flexible program. Immigration visas are now limited to 290,000 per year for all occupations: 170,000 for the Eastern Hemisphere, 120,000 for the Western Hemisphere. Immigrants from the West have no country quotas; acceptance is on a first-come, first-served basis. Eastern immigrants are limited to 20,000 per country.

Foreign born FMGs are admitted to the U.S. as immigrants (permanent residents) and nonimmigrants as immigrants (temporary exchange visitors). Close relatives of U.S. citizens and refugees are exempt from the numerical limitations. The US does exercise the right to establish admission priorities. A preference list with seven categories ranked numerically in order of preference has been established.

The preference list applies only to immigrants from the Eastern hemisphere. Of the seven categories receiving priorities, the third and sixth categories pertain to FMGs. The third category is composed of members of a profession or persons having exceptional abilities. The sixth category is for skilled or unskilled workers in short supply. Members of category one — unmarried children of U.S. citizens — are given greater priority in the immigration process than is category three; category three has higher priority than category six, etc.

Eastern hemisphere immigrants of the third and sixth categories and Western hemisphere immigrants who are not relatives or refugees are subject to the provisions of section 212 (a) (4) which requires a labor certification stating the prospective immigrant's skill is one in which

- (a) there is a shortage of willing, qualified workers, and
- (b) the alien will not adversely effect U.S. workers in this area.

The Department of Labor has placed immigrant physicians under the classification, "Schedule A". This classification means there are not enough physicians in the U.S. who are able, willing, qualified, and presently available for employment as physicians.

Physicians are also subclassified as a "Group I" specialty, which means they receive a special exemption. This exemption allows alien physicians to enter the U.S. without having a job offer from a prospective employer.²⁴

It is both ironic and confusing that ~~xxx~~ one executive department, the Department of Labor, has classified physicians as "under staffed" for purposes of immigration while another executive department, Health, Education and Welfare, in official testimony before Congress stated that the United States may be facing a "surplus" of physicians by 1980. This discrepancy is not due to lack of communication between departments. It is due to each department's attempt to achieve short run goals without the benefit of a comprehensive, national health manpower policy.²⁵

EXCHANGE VISITORS

Another port of entry for physicians is the Exchange Visitor's Program. In 1946 the Fullbright amendment to the Surplus Property Act of 1944 provided for an international educational exchange program. The U.S. Information and Educational Exchange Act of 1948 (Smith-Mundt Act, P.L. 80-402) created an exchange visitor's category and it was this legislation that first encouraged the entrance of FMGs. In purpose the act allowed foreign students to enter the U.S. for full time study. Its intent was for the student to come, study, exchange ideas, receive quality instruction, and then return home with a warm

heart as a life-long ally of the United States.

The Mutual Educational and Cultural Exchange Act of 1961 had similar purposes, yet its amendments encouraged the scholar students to return home after completion of their studies.

Presently, section 212 of our immigration Act governs the Exchange Visitor Program. In the year 1973, 46,468 students — 4,614 physicians — entered the U.S. under subsection 101 (a) (15) (J) of section 212. These "J visitors" are allowed to renew their visas annually, and if they are enrolled in an approved program they can remain until their studies are completed. Up until 1970 J visitors were required to reside for at least two years abroad after completion of their training, before applying to be a permanent resident. In 1970 P.L. 91-225 added section 212 (e) which changed the requirement of two year's absence before being allowed to apply for permanent residency. Section (e) exempts those who have entered the U.S. on private funds from the two year waiting period and provides for waiver of the 2 year waiting feature under other circumstances, most notably if it would cause an exceptional hardship on the student. In actual practice it has been easy for physicians to obtain waiver of this "return-home" provision. Few FMGs have been forced to return to their native homes.

In the 1970 amendment, subsection (4) called for the creation of a special "skills list", "designed to enable interested countries to specify what occupations were "short" of personnel in that country. Any exchange visitor who entered the U.S. whose

occupation was on his country's "skills list" would be forced to return home regardless of whether he had come through the use of public or private funding. This list was first issued in April, 1972 after consultations between the state department and some ninety countries. The Skills List can and has been waived for reasons of "undue hardship" and "public interest".²⁶

The FMG enters a graduate medical training program after having passed an entrance exam, the ECFMG exam, which is administered at 178 exam centers around the world. (Since 1958, 313,885 exams have been taken by 178,324 FMGs). The FMG enters his graduate medical education program as a J visitor. Many FMGS are sponsored by U.S. hospitals who see them as a low cost source of manpower.

The spirit of the law is being ignored. The role of the exchange visitor has been strengthened as a channel of permanent entry by the relaxation of U.S. immigration laws. Since 1971 exchange visitors have been allowed to begin adjusting their visas at any time after arrival in the U.S. This cannot be done ^{however} if the FMG has been financed by the U.S. government or by his own government. Thus, through a series of changes in laws and regulations it is now easy to change an exchange visitor visa to a permanent resident visa. During the period 1962-1972, over 47,000 physicians entered the U.S. as exchange visitors. Over 29,000 have been granted immigration status. And in no cases has the visa status reflected the long term career intentions of the entering FMG. And too, as was shown in the 1971 Senate hearings on Illegal Aliens in the U.S., it is relatively easy for exchange visitors to remain in the U.S. while they are awaiting the availability of visas to complete their immigration adjustments.²⁷

their immigration adjustments.²⁷

It has long been observed that "high level manpower with get up and go will get up and go".²⁸ A total of 66,757 FMGs entered the U.S. between 1965-1971; 21, 891 were immigrants, 44,866 were exchange visitors. Due to inconsistent U.S. immigration regulations, it cannot be assumed that physicians entering as permanent residents on immigrant visas will remain in the U.S., or that those seeking exchange visitor status will return home once their temporary training programs are completed.²⁸

From 1967-1970 about 44% of alien FMGs entered as immigrants, and 52% as exchange visitors. Yet this trend has been changing. In 1971 and 1972 more physicians were admitted as immigrants (53% and 63%) than as exchange visitors. A major portion of these "immigrants" were FMGs who adjusted their nonimmigrant status while residing in the U.S. As an example of this adjustment phenomena, of the 4,270 nonimmigrants entering in fiscal 1972, 1,197 had become immigrants by the end of fiscal 1973. During the period 1965-1973, the number of physicians granted immigrant visas increased from 2,012 to 7,119; the number entering on temporary visas increased from 4,114 to 5,114.²⁹

Until recently the majority of FMGs were from Western hemisphere countries. With the change of our immigration laws, the number of physicians from Asia and other Eastern hemisphere areas has been increasing rapidly. In 1957, 7.8% of FMGs were from Asia; in 1971, 67% of FMGs were from Asia. In 1965 less than 300 immigrants were from Asia; in both 1972 and 1973 over 5,000

Asian FMGs entered the U.S.A. And, not only is the U.S. importing physicians, we are importing young physicians. In addition to their being young, 36% of all FMGs are female, while only 18% of the physicians of the U.S. are female.³⁰

It is most significant that young, female, Asian FMGs are entering the United States. In the next section it will be observed that the U.S. is attracting physicians from Asian countries that are doctor poor. Thus, a physician drain from developing countries to developed countries is subject to many policy considerations. The arrival and performance of a high percentage of female physicians may lead the U.S. to reevaluate its medical school admission policies; presently the U.S. admits far fewer female applicants than do other developed nations.

III. Physician Drain

13

This is every man's country.
Crevecoeur, 1783

Britain is not prepared to invest thousands of pounds Sterling in a medical student only to increase the membership of the American Medical Association.

Sir Kenneth Robinson, Minister of Health

Some of our citizens will have large amounts of money spent on their education, while others have none. Those who receive the privilege therefore have the duty to repay the sacrifices which others have made. They are like the man who has been given all the food available in a starving village in order that he may have strength to bring supplies back from a distant place. If he takes this food and does not bring back help to his brothers, he is a traitor. Similarly, if any of the young men and women who are given education by the people of this Republic adopt attitudes of superiority, or fail to use their knowledge to help the development of this country, then they are betraying our Union.

President Nyerere of Tanganyika

Referring to the loss of physicians from the less developed to the developed countries one educator stated, 'This country is simply stealing talent, and stealing it from countries that can least afford it'.³⁰

After World War II, in a program known as "Operation Paperclip", the United States sought to bring 475 German scientists to America. The program was the first active recruitment by this country of groups having above average intelligence. Today's immigration laws reflect the same trend - they attempt to attract the brightest and the best. The situation is quite different from World War II days, however, in that the immigrants are not coming from developed countries such as Germany, but from the least developed countries of the world. And too, the volume today is far greater than the original 475 scientists.³¹

Irene Butter estimates that a minimum of 40,000 to 50,000 medical graduates per year are currently moving from one country to another, (the maximum figure may be 100,000), and that the migration pattern is precisely from the less developed to the advanced countries.³² The U.S. is the prime and increasing recipient of foreign physicians. The less developed countries are the greatest source of supply.³³ In a report by the U.N. Secretary General concerning the outflow of trained personnel from less developed countries, the Secretary General said "There is a universal preference for the highly trained, the elite immigrant".³⁴

The reasons elite, highly trained people migrate can be classed into "push" and "pull" categories. Push categories are usually due to deficiencies in the "donor" countries, such as (1) lack of adequate opportunities for post graduate training and research (2) a relative over-production and underutilization of medical manpower (3) inadequate rural and urban health services (4) lack of assured appointments and/or limited financial remuneration.³⁵ Other factors such as political and administrative policies also are significant.³⁶ In addition, the cultural and intellectual environments often promote migration such as emigration.³⁷ It has been found e.g. that most Indians who migrate do so because of anticipated or actual financial privation at home.³⁸

There is a general economic pull of FMGs due to gaps in income and salaries. Other "pull" factors include (1) stability,

(2) security, (3) a chance to realize one's professional abilities, (4) better educational facilities, (5) a higher degree of scientific advancement, and (6) a higher level of living.³⁹

It has been already shown that most FMGs change their visitor's status to immigrant status and remain in the United States. This means that some countries suffer an irreplaceable loss of physicians. The non return of a single Nigerian medical graduate from post graduate training in the U.S. is a serious loss to that much deprived country.⁴⁰

Few graduates return; however, the donor countries by and large do little to encourage the dissipation of information regarding job opportunities in the country. Some countries such as Columbia have a well organized, highly efficient tracer system which supplies information to natives engaged in foreign trainee programs. The recovery and retention of FMGs in the Columbian program is quite high. Other countries such as India have had programs, the purpose of which was to actively recruit Indian scientists abroad, collapse. Another complicating factor is that many FMGs are educated in the U.S. training programs above their ability to return. Many enter training programs studying subspecialties which their home country is unable to support, either by patient population or through inadequate technology. Thus, entrance into many U.S. graduate training programs would point toward a doubtful career at home.⁴¹

The migration of the world's medical elite in a large volume to the U.S. has led many to term the phenomena a "brain drain"

Some object to this pejorative term, however, and argue that the phenomena is simply a matter of the number of physicians taking better jobs, actions which are legitimate and proper to their expertise.⁴² Henry Fairlie, for example, states categorically that "There is no brain drain". He views physician migration as an exchange of economic and social commodities, the net export coming from the less developed countries, and the net import resting with the most advanced countries.⁴³

Others go beyond the mark to argue that the individual physician performs a greater service to humanity by leaving his native country than he does by returning home. These authors point out that the specialist on cancer research from a small developing country who seeks international contacts and research facilities in order to satisfy his professional ambitions may be making a greater contribution to his nation than if he remained at home. After all, one-half of this nation's nobel laureates in medical science are FMGs.⁴⁴

Certainly, they argue, the world of scholarship is the last which should allow social, political, or nationalist considerations to be paramount. No barriers should be placed against the free movement of genius throughout the world. It would be out of perspective to view the training of students in this country as anything but a large, positive gain to the world.⁴⁵

The tendency of this line of reasoning is to equate all FMGs as repressed super-scientists, to confuse the actual situation with abstract ideologies of freedom of scientific inquiry and the

development of future Einsteins. Against such interpretations are the unalterable, incontrovertible facts that such emigration represents a fundamental loss of vital human resources necessary for development. Most FMGs are not nobel laureates and their range of contribution is limited to concrete service - not the advancement of scholarship. They might very well perform valuable concrete service to their nations rather than serving some abstract notion of the interest of humanity. Thus, on the other hand there are arguments that little or no good comes from the expensive movement of physicians from less to more developed countries.

Actually it creates some unconscionable harms. H. Myint concludes:

From the welfare point of view, the migration of doctors from the under developed countries, where the ratio of doctors to the total population is so low, to the advanced countries where the doctors are relatively more numerous, is the most disconcerting aspect of the brain drain...⁴⁶

Migration from developing countries portends serious inequities in the availability of quality medical care. In these countries physician migration means a loss of urgently needed, highly educated individuals. In the United States the physician to population ratio is one to 1,500 people — a soft workload compared with that of India (1/5,800) or Thailand (1/8,600). Yet in August 1975, when 125 students graduated from medical college in Gujarat, India, 85 of them promptly chartered a bus and arrived at the U.S. consulate in Bombay to apply for U.S. visas. And on another occasion virtually the entire first graduating class of a new^{medical} school in Chiangmai, Thailand, chartered an airplane and flew off to the United States. One-fourth of Thailand's 4,000

doctors are now in the United States.⁴⁷

Korea, where more than one-half of all sections of the country have not a single doctor with modern medical training, provides 20 anesthesiologists for the staff of one East Coast American hospital. Ethiopia has a physician to population ratio of 1/69,000. Indonesia's is 1/35,000 with a rural ratio of 1 physician per 180,000 people. These glaring inequities are all the more astonishing when placed against the fact that the U.S. could do very well without FMGs — that U.S. medical schools turn away qualified American applicants in large numbers. From other than the welfare point of view, this migration presents other major problems. In Brinley Thomas' point of view, the U.S. deprives foreign countries of their "crucial critical mass".⁴⁸ The term pertains to the take-off stage in medical development. The young doctors are needed to "prime the pump".⁴⁸

The short term effects of the migration of FMGs to the U.S. are measured by preventable disease and death. The long term effects by retarded development of institutions and health services. This loss jeopardizes the growth potential of donor countries, for potential leadership talent and valuable educational investments leave the country. The drain prevents the establishment of a scientific - technological base, and this development gap perpetuates, indeed feeds on, the gap itself - the drain itself. Thus, the migration also causes a delay in the advances in health standards in the developing countries. Of Lebanon a Unitar study said: "The loss of physicians with residency training has seriously

affected the health service as well as the establishment of new medical schools." 49

Developing countries "face a situation which is intensified by unused, under used, misused, or missing talents and skills..."

This deprives developing nations of human capital for achieving their major national goal, modernization. It "definitely retards development". 50

"Some countries have subsidized the education of their physicians and have subsequently lost them..." India, for example, the largest contributor of U.S. doctors, lost \$57,180,000 in 1971 and 72 when 2,859 of its doctors emigrated to the U.S. Other countries are receiving a benefit of physicians for which they have not paid the cost. It would cost the U.S. an estimated 925 million dollars to replace the FMGs licensed between 1961-1965 with American graduates. Dr. Kelly West of the State Department says "The value of the physicians coming to the U.S. (from Latin America) is roughly equal to that of all U.S. medical assistance to Latin America." Irene Butter comments that this money flow virtually reverses the flow of U.S. foreign aid, and as will be discussed in another section, perverts America's foreign aid policy. 51

The geographic maldistribution of physicians within the U.S. is aggravated by the arrival of foreign physicians. They shun rural areas and collect predominately in the large cities. They are in competition with USMGs for houseofficer training programs many of which are most suitable for physicians who will be remaining in the U.S. FMGs aggravate the health situation in the U.S. and their home countries both as to the health welfare of the

population and as regards the economic investments in their education. In addition they contribute to an international maldistribution of health personnel. This fosters the ill-will of many foreign countries toward the U.S., whose immigration laws encourage the flow of the elite to our physician-rich country.

In the quagmire of international medical manpower discussions the accusatory diatribes of underdeveloped countries center on debits and credits, losses and gains of physicians on their country's health balance sheet. Secretary General Kurt Waldheim acknowledged that this physician drain is a most serious problem:

The net outflow of trained personnel from developing to developed countries is significant enough to justify international concern and to warrant the formation and implementation of policies to reduce, if not stop, this net outflow.⁵²

IV. International Law

21

Freedom of movement constitutes a basic right for workers and their family. Mobility of the labor force... must guarantee the worker the possibility of improving his living and working conditions and securing his social advancement while helping to satisfy the economic requirements of the member states.

Preamble to the Treaty of Rome

Every person has the right to leave any country, including his own, and to return to his country.

Universal Declaration of Human Rights

The right to leave any country including his own, and to return to one's country.

- International Convention of the Elimination of all forms of Discrimination
- International Covenant on Civil and Political Rights
- Organization of American States Convention

It is an accepted maxim of international law; that every sovereign nation has the power, as inherent in sovereignty, and essential to self-preservation, to forbid the entrance of foreigners within its dominions, or to admit them only in such cases and upon such conditions as it may see fit to prescribe.

Ekin v U.S. 142 U.S. 651 (1892)

There is a body of opinion which stresses that unilateral governmental or statutory steps to curtail or stop the international migration of physicians and other trained personnel is not in the long term best interests of either the donor or recipient countries.⁵³

EMIGRATION

To many the right to emigrate is synonymous with the Universal Declaration of Human Rights, adopted by the United Nation's General Assembly in 1948. Article 13 (2) states, "Every person

has the right to leave any country, including his own, and to return to his country.⁵⁴

The U.N. General Assembly has included this statement in several subsequent statements and declarations of purpose dealing with the protection of human rights. It is found:

- In the 1960 Declaration on the Granting of independence to Colonial Countries and Peoples
- In the 1963 Declaration on the Elimination of all Forms of Racial Discrimination
- In the 1965 International Convention on Elimination of all forms of Discrimination
- In the 1966 International Covenant on Civil and Political Rights.⁵⁵

In addition the Declaration has been used to interpret articles 55 and 56 of the U.N. Charter, and it is used along with the equality provisions of the Preamble to the U.N. Charter to solidify a person's right to enter his own country.

Most developing nations see the right to leave a country as subject to limitations and qualifications. The right of donor nations to control emigration of trained personnel is not looked upon by favor in the international community. It is generally accepted that the right to emigrate and return to one's home shall not be subject to any restrictions except those which are provided by law, or are necessary to protect national security, public order, public health, morals, or the rights and freedoms of others. There are times however when donor nations may feel compelled to violate these principles of emigration rights. India e.g. has passed ammendments granting Parliamentary authority to suspend the fundamental rights of its citizens, and may choose to restrict emigration from India as it has chosen ^{to} abolish the

administration of the ECFMG exam to Indian physicians.⁵⁶

Historically compliance with International law on the part of states ultimately is strictly voluntarily. Redish states that

(R) esolutions of the (General) Assembly are not per se binding although those rules of general international law which they embody are binding on member statesthe body of resolutions as a whole, taken as general customary law, undoubtedly provide a rich source of evidence.

The basic consensus of nations has always constituted customary international law, and the Resolutions of the General Assembly are presumptive evidence of international custom.⁵⁷

A memo from the U.N. office of legal affairs outlines the scope of authority of U.N. Declarations and Resolutions:

4....A "declaration" or a "recommendation" is adopted by a resolution of a U.N. organ. As such it cannot be binding upon member states, in the sense that a treaty or convention is binding upon the parties to it, purely by the device terming it a "declaration" rather than a "recommendation". However, in view of the greater solemnity and significance of a "declaration," it may be considered to impart, on behalf of the organ adopting it, a strong expectation that members of the international community will abide by it. Consequently, in so far as the expectation is gradually justified by state practice, a declaration may by custom become recognized as laying down rules binding among states.

5....In conclusion, it may be said that in U.N. practice, a "declaration" is a solemn instrument resorted to only in very rare cases relating to matters of major importance where maximum compliance is expected.⁵⁸

J. Castaneda in Legal Effects of U.N. Resolutions states that the adoption of a resolution of an international organization on a question of abstract legal principles constitutes important evidence of international law. He gives more weight to such

pronouncements as he states,

The recognition and formal expression of a customary rule or a general principle of law by the General Assembly constitutes a *juris-et de jure* presumption that such a rule or principle is a part of positive international law, that is to say, a legal assumption or fiction that does not allow proof to the contrary, in the face of which an opposing individual position therefore lacks legal efficacy.

IMMIGRATION

It is a well established general principle that a state may forbid the entrance of aliens into its territory, or admit them only in such cases as commend themselves to its judgment. Article two of the U.N. charter pertains to a state's exclusive jurisdiction over domestic affairs. It is generally accepted that a body politic (receiving country) has the competence (inherent in the concept of state sovereignty) to set limitations on the admission of aliens either for temporary or permanent purposes.⁶⁰

The rule was stated clearly by Vattel in 1758; the dictum in the case of Nishimura Ekiu v U.S. 142 U.S. 651 (1892) is often quoted. There is no obligation on the part of a particular state to admit all or any of those who only come with the intention of becoming permanent residents. The total exclusion of all immigrants may become a necessity. There would seem no doubt that the general principle of the right of exclusion might be given practical application without giving rise to legal grounds of protest from other states. To exclude all aliens impartially raises no issue

of discrimination.⁶¹

Considering the universal restrictions placed on immigration and the almost total exclusion of aliens by some countries, it is suprising to discover there is a widespread consensus favoring a general duty in international law to receive aliens.⁶²

Because of an interest to protect the rights of the world's immigrants an international conference of non-governmental agencies drew up a series of principles to form the basis of what is today termed "The Immigrant's Charter".⁶³ It states,

- (1) There should be no discrimination, defacto or de jure against a migrant for such reasons as race, religion, political opinion, financial means, country of origin or status as an alien.
- (2) Every migrant should have the right in the receiving country to treatment no less favorable than that granted to national of that country.
- (3) Every migrant should have the right to do work in accordance with his abilities and within the laws of the receiving population, and should enjoy equal rights as regards conditions of employment, wages, freedom of trade, union affiliation, public assistance, and social security.
- (4) Every migrant should bear in mind that these rights⁶³ imply a corresponding series of duties to his community.

The question of nationaltiy has traditionally been considered within the domestic jurisdiction of states, but there exists substantial evidence that the definiation of nationality must satisfy and be compatible with international standards and rules of law. While cases on the admission of aliens may be decided entirely on the basis of national law, the factual situations are of interest to international law because international claims may be concerned with these questions.⁶⁴

Two cases can be used as examples: In the Nottebohm case the International Court of Justice held that it had jurisdiction to determine the international legal effect to be given to Liechtenstein's formal grant of nationality to a person with questionable ties to that country. The court held, "It is international law which determines whether a state is entitled to exercise protection." The second case involved nationality decrees in Tunis and Morocco. The court in this case held, "The question whether a certain matter is or is not solely within the jurisdiction of a state is an essentially relative question: It depends upon the development of international relations"⁶⁵

Eminent statesmen and jurists insist that immigration questions are not a typical subject for judicial settlement or arbitration. Government's unwillingness

to submit such questions to judicial settlement is not the result of the conviction that their rights cannot be upheld by a clear pronouncement of the law but their reluctance to entrust the decision on matters of vital national importance to outside bodies over which they have no control. It is the absence of confidence in the judicial character and impartiality of international tribunals and the traditional assertion of national sovereignty as the ultimate judge in matters of importance, that lie at the bottom of the supposed non-justiciability of such disputes.⁶⁶

V. American Foreign Policy

27

FMGs are being used to fill the health needs of the country ...and I don't think in and of itself it is necessarily a bad thingthey come here, apply for credentials, and when they are found qualified ...they practice. The most important thing to consider here⁶⁷ is the satisfaction of the need for medical personnel.
Casper Weinberger, Secretary, HEW

The (Physician) drain ...is not a problem to be solved, but a situation to be adapted to. And we are dealing with a process, I think, and not an event.
Charles Kidd, M.D.

Our foreign policies are often much more closely related to our domestic policies than we realizeindeed our foreign policies can come so sharply in conflict with our domestic policies that, unless this conflict is both understood and resolved by government leaders, domestic pressures can completely⁶⁸ undermine and even nullify our foreign programs.

The United States has become a graduate school for much of the developing world.

These movements of students and scholars are an indispensable aspect of freedom. Policies should be avoided which would weaken this movement, the yeast of the bread of libertymost of the men and women trained here sooner or later return to their homes to take a leading part in building strong institutions there. They have a much better knowledge, a more intimate knowledge of the United States than most of their country men, and most of them remain for the rest of their lives among our best friends abroad.....

Eugene V. Rostow, Under Secretary of State

With one hand the U.S. is giving (foreign) countries millions to develop themselves. And with the other it is casually taking away the seed corn of future leaders in natural science, health, and technical knowledge. These are even more precious to the country than food or machinery.

Christian Science Monitor 31 January 1969

This country is the recipient of substantial 'reverse foreign aid'. The United States is reaping the rewards of investments made by other countries in the education of physicians, and those countries are suffering a long-term loss of physician services.⁶⁹

AMERICAN FOREIGN POLICY

There exists today a world-wide market for physicians. The international standardization of training for physicians has produced a situation in which a physician could be born in one country, pursue graduate medical education in a third country, and move elsewhere for training and/or practice.

The United States is in a quandary: if we admit physicians, we hurt their home countries; if we fail to admit physicians, we deprive our country. There are those who argue that freedom of movement is "essential to the expression of talent, and its curtailment to any significant degree would be a global tragedy".⁷⁰ This physician drain has indeed become a dominant problem in international relations. Serious concern has been manifested by the losers of the physicians, and by the principal gainer, the United States. Highly charged with emotion, this issue has become the subject of discussion in the U.N. and has been one of the most volatile problems in the post-war world. Many citizens of the U.S. have responded to this problem from a sense of national guilt.

Not only have we given countenance to this physician drain, we have encouraged it. We have made it too easy for FMGs to come here to stay. To many donor countries physicians are an

unbearable loss. This drain affects foreign policy "not so much as a specific issue in state-to-state relations but rather as a generalized all embracing problem that affects the growth and maturation, or retardation and decline of nations".⁷¹ It serves to widen the gap between the United States and developing, donor countries.

The U.S. Department of State continues to view the drain within the context of what it terms "people-to-people interchanges". They see this exchange of talent as a means to conduct American diplomacy through potential returning good-will ambassadors. The official view of the department is changing some from "not necessarily a bad thing" to ... "a problem, not just an opportunity".⁷² It continues to view the drain as essentially a problem for the less developed donor countries to resolve. The official Policy of the U.S. remains to be tied to our commitment to the principle of free immigration. It is consistent with the Committee on the International Migration of Talent's statement that it was most difficult for developed countries to determine the effects on less developed countries and fit immigration policy to their needs. If the LDCs

percieved migration harming them, and that this injury should be reduced by controlling the movement of people, it is their primary obligation to design, install and operate the appropriate methods. The imposition of stringent controls by the developed countries is not a proper policy.

In view of this state Department policy, the Department of Health, Education and Welfare in their development and projection of health manpower needs and policy, still relies on FMGs as a

source of U.S. ^{physicians} supply. 73

Our foreign policy seems to be draining off physicians faster than we are helping create them "while on the one hand we give ...with the other hand we take away...." We are in competition with the results of our own assistance policies. The foreign assistance Act of 1961 states that the United States should assist the people of LDCs in their efforts to acquire the knowledge and essential ingredients for development. Included in the principles to be followed ^{were} included "...assistance ...and the opportunity to gain the basic knowledge and skills required to make their own way forward to a brighter future". 74

Our foreign aid has devoted substantial funds with high priority given for the training of professional manpower in LDCs. If the physician drain is undermining and canceling the potential good will created by our foreign aid program, the U.S. should contain our short-run domestic interests in favor of our longer range interest in the welfare and progress of man. 75

The physician drain is becoming increasingly more serious; pressure has been put on our state department by countries that have asked that the U.S. send physicians back home when their programs are over, and not encourage them to study sophisticated subjects, such as psychiatry, for which there is not yet a need in their native country. The government of India has prohibited the administration of the test required of physicians before they can enter the U.S.; several African countries are placing restrictions and pressures of physician emigration; and the

Philippines is considering a required period of service after graduation (like is imposed in Mexico and Iran) in an effort to keep their doctors at home.⁷⁶

Robert Bowie states that "the LDCs have become the forgotten men of U.S. foreign policy." But this is changing: heretofore foreign governments have been inclined to acquiesce quietly in suffering the loss of their physicians. It is no longer a hidden foreign policy issue. As the poor LDCs continue to subsidize the rich with expensively produced physicians, there is an increased likelihood of confrontation between the rich and the poor. Many of the LDCs are real or potential international trouble spots. Unless this problem is understood and resolved our nation's foreign programs may be nullified with the following progression occurring;

As the development widens, tensions increase between the rich and poor nations.... Social and economic progress among the LDCs become arrested; frustration, anxiety and despair set in as hopes and expectations diminish; bitterness and resentment are directed against the rich... global instability results; the U.S. as the world's richest nation, cannot avoid being enmeshed in the international troubles that flow from these economic conditions. Among development specialists it is virually a self-evident truth that growing impoverishment of the third world has potentially adverse consequences for American diplomacy.⁷⁷

VI. Solutions

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A medical degree unlike many other professional credentials, commands international recognition.

On grounds of both moral and political realities it is desirable that the United States and its medical education institutions should provide assistance to developing countries. And, in order to further assist in the improvement of medical education and health care abroad it is desirable that the U.S. should cooperate with countries that wish that their students return home following U.S. graduate study, for reducing the drain of physicians from underdeveloped countries will provide more foreign aid than any program of monetary assistance.⁷⁸

Many improvements could be made in the structuring of U.S. medical education programs which would (1) increase the effectiveness of U.S. training and (2) provide added inducements for FMGs to return home. At the conclusion of their experience in the U.S. many foreign physicians will no longer either culturally or professionally be able to fit into their own country's health delivery systems. Training programs for FMGs should be patterned after the health care needs of the respective foreign countries. The rationale here is that the appropriate doctor will be the best doctor. If 80% of the population of a physician's home country is rural, then 80% of the medical students from that country should be educated accordingly. An excellent example of the tailoring of programs to meet health care needs is the program for Indonesian psychiatrists at the University of Hawaii.

As they exist today most programs spend large amounts of money on training but give no thought to satisfying specific needs in the home country. FMG training in the U.S. ought to meet two categories

- (1) what is unavailable at home
- (2) what can be utilized at home.⁷⁹

Because it is desirable that physicians from abroad return to their countries a list of suggestions for what foreign countries can do to encourage return is appropriate here.

- (1) monetary inducements
- (2) assured of positions in home country before leaving for U.S.
- (3) ensure support for sustained contact and communication with the more advanced countries, access to foreign publications, etc.
- (4) The American Journal of Psychiatry even suggests periodic travel leave with pay
- (5) help in raising salaries abroad and assistance in revision of salary structures; assist in restructuring of investments in health manpower policies and programs.⁸⁰

More strict actions are in order should persuasion fail.

Columbia, for example, has "Icetex 1950," which

- (a) provides loans for physicians studying abroad
- (b) has a clearinghouse through which foreign scholarships are granted to Columbian nationals for study abroad.
- (c) arranges the release of currency for those privately financed
- (d) has a clearinghouse for jobs for those returning.

Under this program the FMG is required to sign a contract to work in Columbia from 1-3 years for every year of study abroad. Under this program 97.7% of those receiving Columbian assistance returned to work in Columbia.⁸¹

Steps of persuasion suggested for the U.S. have been these:

- (1) decrease the number of residencies available to FMGs. The number of first year positions in approved programs of graduate medical education could be adjusted gradually so as to exceed only slightly the expected number of graduates from domestic medical schools and to provide sufficient opportunities to highly qualified FMSs. In addition the staffs of U.S. hospitals must be fully licensed FMGs.⁸²
- (2) decrease the number allowed to take the ECFMG test; stop certifying FMGs in specialties.⁸³
- (3) increase technical assistance to foreign doctors.
- (4) accept only those assured of positions in home countries.
- (5) ^{pe}the Exchange Visitor's Visa Program; (a) terminate it; replace it with a more systematic and nationally coordinated exchange program involving formal agreements between the U.S. and the governments of other countries,⁸⁴ or (b) require visitors to leave the U.S. for a minimum period; (c) screen physicians to see that they are committed to returning home, that they are pursuing a program most beneficial to their home country. The screening committee could be in the FMGs home country, or (d) require sponsorship by the physician's host country.⁸⁵

There is general agreement that the EYP has become a vehicle for generating services and entry into the U.S. medical profession, not a vehicle for providing graduate education to students from abroad to use in their home countries. These selfish loopholes should be plugged.

Often the most important method is not of persuasion, but of law. There needs to be a complete revamping of our nation's immigration laws as they apply to physicians. All countries have the right to exclude aliens and this right should be used,

since it is clear that the right to restrict emigration is clearly contrary to e.g. the Universal Declaration of Human Rights and customary international law. Feldstein believes U.S. Immigration policy should not be related to the health manpower needs of the U.S. but to the disadvantaged needs of less developed countries. In determining which countries have physician manpower shortages and controlling the immigration of physicians from these countries, the U.S. should seek assistance from the U.N. and thus avoid any perception of interfering with the internal affairs of foreign states.⁸⁶

Established precedent for such immigration law administration exist in international law. Most recently Canada (1972) started prohibiting housestaff from gaining immigrant status without first going back to the home country and making application through normal channels. Similarly, it has been suggested that all "J" immigrants must be prohibited from adjusting their status before first returning home for a specified period, and that use of "J" exchange visitor nonimmigrant visas for hospital staffing purposes be curtailed.

The most direct way to change FMG physician migration patterns would be to change the requirements for admission to the U.S. by requiring an exchange visitor to be absent from the U.S. and to reside in his home country for 4 years before being allowed to apply for a permanent resident visa. This is the position recommended by the government of India. It would prohibit the FMG from residing and working in a third country (e.g. Canada)

for a period of time before returning to the U.S. Others suggest that medical personnel be removed from the U.S. Department of Labor's "Schedule A", national shortage category.⁸⁷

The Secretary of HEW suggests: (1) remove physicians from the national shortage list and (2) modify the exchange program. Feldstein suggests that the issuance of "occupational preference" visas with the restriction that the skill possessed by the prospective immigrant not be in short supply in the potential immigrant's home country would achieve good results.

One could use the Department of Labor's certification requirement to document that FMGs are competing with American physicians. Restricting FMGs using this approach is open to fewer charges of discrimination.

Berman argues that the U.S. immigration policy should not preclude a person's entering the U.S. because he is a physician, but that the U.S. should not take advantage of its economic strength to drain limited human resources from developing countries. On this reasoning the occupational preference visa category status presently extended to physicians as immigrants should be rescinded.⁸⁹

The United States suffers less from a gross quantitative shortage of doctors than from a poor distribution of such physician services as are presently available. Unless we make some great strides forward in the area of research in the delivery of health services and unless we increase our output of physicians we will have

to continue to rely on personnel trained in other countries.

In order to decrease the number of FMG's we must have a greated output of USMGs. Dr. G. Halsey Hunt states,

The long range solution of the brain drain in medicine will require the development of new medical schools in the U.S. and the enlarging of some of the present schools to provide a much greater output of U.S. physicians than we now have.

The remedy then lies in expansion of domestically trained medical personnel and a heightened efficiency of their use.⁹¹

Because of a lack of space we turn away over 20,000 qualified pre-medical students annually from U.S. medical schools, and it is anticipated that our basic need for physicians in the 1980's presumably can be staisfied from domestic sources. If the anticipated number of graduates is insufficient to meet our nation's need for physicians, adequately planned and financed programs should be initiated to further increase the class size of domestic medical schools. It seems inappropriate that the U.S. with its existing resources should depend to any significant degree on physicians supplied by other countries.⁹²

VII. Notes

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VI NOTES

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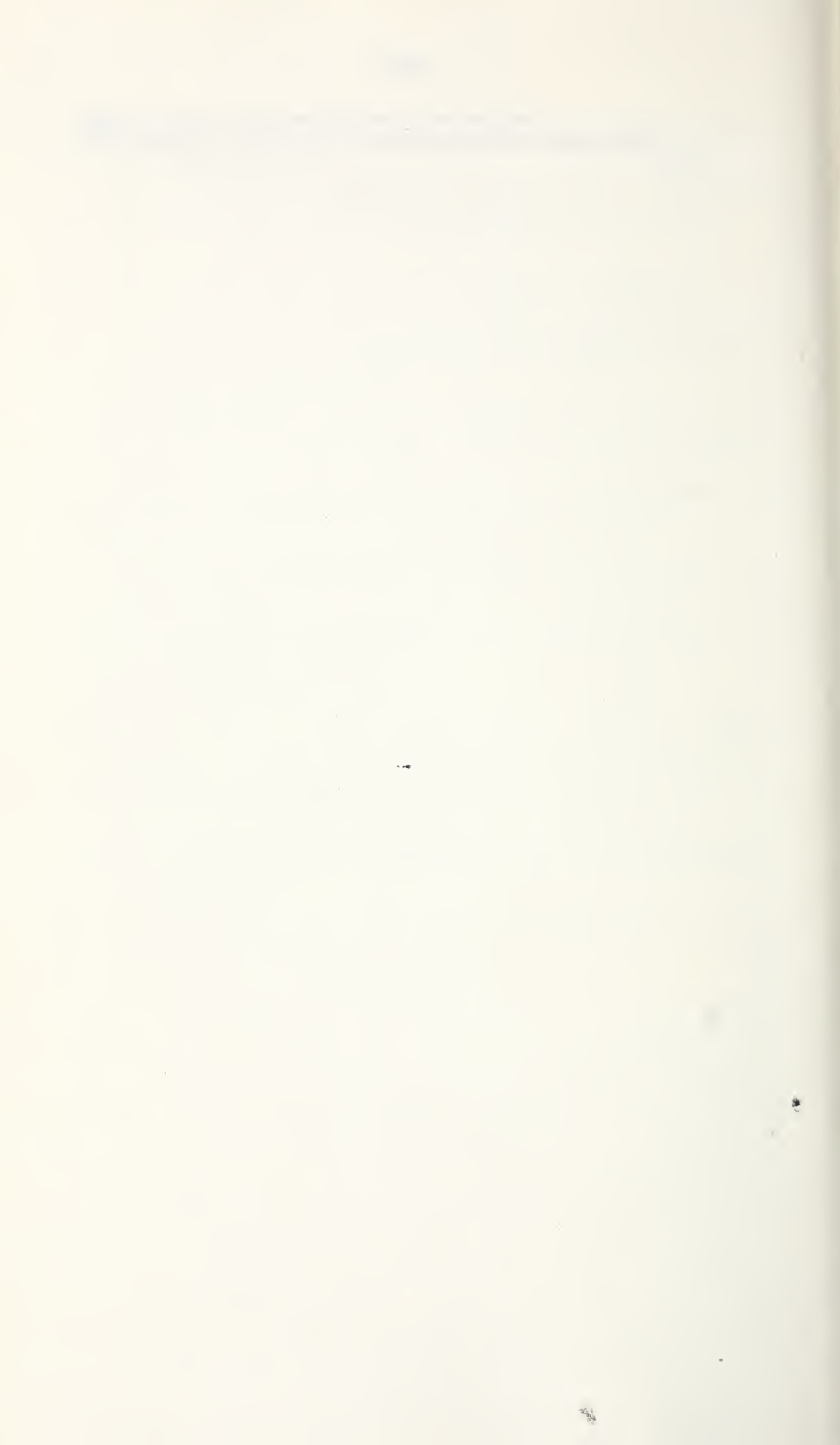
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Senator BEALL. The hearing stands adjourned.
[Whereupon, at 12:18 p.m., the subcommittee adjourned.]









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